Supreme Court
FILED

04-136 JUL 23 2004

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NO. _____

IN THE
Supreme Court of the United States

TENNESSEE LABORERS HEALTH & WELFARE FUND,

Petitioner

v.

ELIAS RODRIGUEZ, *Respondent*

ON PETITION FOR WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

In a plaintiff's declaratory judgment action, determinable under the Employment Income Security Act of 1974 (herein ERISA), 29 U.S.C. §§ 1001, *et seq.*, brought against Trustees of an ERISA health fund concerning their decision that benefits had been mistakenly paid on plaintiff's behalf due to false reports by plaintiff's employer, and with the trial court's declaration based in part upon a refusal to consider parts of the record upon which the Trustees rendered their decision about the false reports—

Question No. 1: Did the Court of Appeals err in adopting and applying to the ERISA health fund the "make whole" doctrine (and its subsequent subsidiary rules) from the law of commercial insurance, something wholly unrelated to the law of Trusts which is the common-law basis for construing ERISA plans as demonstrated by *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80(1989), *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987), and *Harris Trust and Savings v. Salomon Smith Barney,* 530 U.S. 238, 120 S. Ct. 2180, 147 L. Ed. 2d 187 (2000)?

Question No. 2: When arguments of a losing party in an appeal, are presented in written briefs, and, if correct, would require a different decision on the merits of an appeal, do Rules 35 and 40 , F.R.App.P., when properly construed in light of the

Constitutional mandate that law govern all judicial decisions,[1] **obligate** the intermediate appellate court to accurately state and attempt to rationally answer, either in its opinion or upon a respectful petition for rehearing, the losing party's pretermitted or judicially misstated legal points, particularly in light of Rule 40's implication that a change of decision may be required if, in its written opinion, "the court has overlooked or misapprehended" any "point of law or fact"?

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[1] To validate the propriety of this question, Petitioner attaches copies of its Court of Appeals Petition for Rehearing (Appendix F) and of excerpts from its pre-decision briefs (Appendix G).

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CITATION TO REPORT OF OPINION

The District Court Orders and Opinions are unreported, and the citation to the Decision as to which the writ is requested is:

ELIAS RODRIQUEZ, Plaintiff-Appellee v. TENNESSEE LABORERS HEALTH & WELFARE FUND, Defendant–Appellant, Sixth Circuit Court of Appeals No. 02-5601, 89 Fed. Appx. 949; 2004 U.S. App. LEXIS 2067; 32 Employee Benefits Cas. (BNA) 1449 (February 6, 2004).

BASIS OF JURISDICTION

(i) The Judgment of the Court of Appeals was entered February 6, 2004.

(ii) The order overruling the Petition for Panel Rehearing and Suggestion for Rehearing *en banc* was entered April 29, 2004, and no time extensions have been granted to file this Petition.

(iii) The statutory provision believed to confer on this Court jurisdiction to review on Writ of Certiorari the judgment in question is 28 U.S.C. § 1254(1). The basis of jurisdiction of the Court of first instance was 28 U.S.C. § 1331 and 29 U.S.C. § 1132.

CONSTITUTIONAL PROVISIONS AND STATUTES

The constitutional and statutory provisions (reprinted *infra*, Appx. E) involved in the case are the Constitution, Art. VI, Second Paragraph (Supremacy Clause) and the Fifth Amendment (Due Process Clause), 28 U.S.C. §§ 1254, 2201, and 2202, 29 U.S.C.§§ 1022, 1024, and 1132, Rules 54(b) and 59(b), Federal Rules of Civil Procedure, and Rules 35 and 40, Federal Rules of Appellate Procedure.

STATEMENT OF THE CASE

The ERISA health fund through its Trustees paid benefits of $238,638.11 on behalf of plaintiff after his injury in an April 1999 automobile accident. Plaintiff requested the Trustees to forego the health fund's entitlement under an assignment/subrogation agreement to a $116,666.00 settlement he reached with a third party causing this injury, and the Trustees reduced the amount to $57,139.94. Plaintiff requested a waiver of this reduced amount, and while considering the request, the Trustees discovered plaintiff had not been entitled to any benefits because he did not fulfill the monthly work requirements for the period between October 1997 and April 1999[2], a period during which his employer submitted false

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[2]After becoming an employee in July 1997, plaintiff suffered an on-the-job injury in October 1997, and while

reports of hours worked, to cover gratuitous contributions the employer made to maintain plaintiff's eligibility during this 1-year, 5-month period as supposedly representing "hours worked" by plaintiff, whose work career actually ended four months after he initially became an employee. The Trustees refunded to the employer the contributions made during the period of false reporting, yet stood by their original reduction to $57,139.94 if plaintiff would meet certain limited conditions to independently establish his eligibility for benefits. Absent plaintiff's meeting conditions for eligibility, the Trustees decided plaintiff did not have an obligation for assignment/subrogation and determined to seek reimbursement from health care providers which had received the $238,638.11. Plaintiff rejected the conditions to establish his eligibility and filed the declaratory action.

Plaintiff sought a declaratory judgment of the invalidity of the Fund's claimed refund rights under 28 U.S.C.§ 2201 and § 2202, as being an ERISA-controlled determination under 29 U.S.C. § 1132. The District Court rendered its declaratory judgment for Plaintiff by holding *(i)* the Trustees improperly decided plaintiff was ineligible due to the employer's false reports of hours worked because the phrase "representing hours worked" was ambiguous so as to warrant application of the

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disabled from a return to work, suffered the April 1999 automobile accident injury which led to his receipt of benefits after he signed an assignment/subrogation agreement.

contra proferentum rationale;[3] and *(ii)* with plaintiff eligible for benefits despite the false reports of work, the assignment/subrogation agreement was not enforceable under the insurance law "make whole" doctrine unless the Trustees promulgated both a plan provision and summary plan description declaring the insurance law doctrine not applicable because the federal common law of commercial insurance applied to ERISA plans via *Copeland Oaks v. Haupt,* 209 F.3d 811 (6th Cir., 2000) and its progeny. In the process of deciding in favor of plaintiff, the trial court refused to consider a portion of the Administrative Record earlier inadvertently omitted, but supplied in support of a motion to modify its interlocutory (Rule (b), F.R.Civ.P.) order for the Motion's failure to meet the "newly-discovered evidence" and other requirements of Rule

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[3] The District Court supported this conclusion with a holding that the Plan's provisions requiring actual work for qualification would be invalidated in not providing credit for "work done" during vacation time, as violating the Family and Medical Leave Act of 1993, 29 U.S.C. §§ 2601, *et seq.*, although there was no evidence that Plaintiff was within that Act's coverage, and a part of the Administrative Record initially omitted (but later supplied in support of a motion for the District Court to modify its interlocutory order) affirmatively proved that Plaintiff's employment was not within its coverage.This late-supplied part of the Administrative Record, which the District Court refused to consider, also contained the evidence supporting the Trustees' decision of Plaintiff's non-entitlement to *any* benefits.

59(b), F.R.Civ.P., governing the modification of final judgments.

The Court of Appeals affirmed the trial court decision about eligibility by concentrating on the single isolated phrase "representing hours worked," in disregard of numerous other written provisions governing the eligibility of employees for benefits and which require employees to have actually worked, including, *e.g.*, a continuing requirement for minimum hours worked during a month to earn benefit entitlement the third month thereafter.[4] The decision of the Court of Appeals essentially upheld the trial court's decision about eligibility with slight differences, one being the Court of Appeals concluding there was no ambiguity in the phrase "representing hours worked," but that "hours of work" did not mean or even imply that hours for which an employer paid contributions actually had to be worked: "The Fund contends that additional plan provisions support its interpretation of the disputed provision. . . . The plain meaning of the plan language and the document *taken as a whole [sic]* make no requirement that an employee work to continue to receive benefits." *Rodriguez v. Tennessee Laborers Health & Welfare Fund,* 89 Fed. Appx. 949, 954, 955; 2004 U.S. App. LEXIS 2067; 32 Employee

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[4] There were many other relevant provisions, including one for an "hour bank" of excess hours worked over a maximum required for eligibility with the banked hours to be used as "hours worked" in future months in which the employee did not work.

Benefits Cas. (BNA) 1449 (February 6, 2004) (emphasis added).

Having deemed Plaintiff eligible to receive benefits, the Court of Appeals reaffirmed its prior decision that the "make whole" rule from the common law of insurance applied to all ERISA health plans. This applicability originated in *Copeland Oaks v. Haupt*, 209 F.3d 811, 813 (6th Cir. 2000) which made extensive reference to texts on insurance law. As a result, the Court of Appeals concluded it was necessary for the Trustees to have utilized "language conclusively disavowing" the make whole doctrine in the assignment/subrogation agreement signed by plaintiff and to also include the disclaimer in the summary plan description required by 29 U.S.C. § 1022. *Rodriguez v. Tennessee Laborers Health & Welfare Fund*, 87 Fed. Appx. at 956 *et. seq.* In so ruling, the Court of Appeals deemed inadequate the following statement which was included in the detailed description of benefits promulgated under the requirement of 29 U.S.C. § 1024: "Common law doctrines such as 'make whole' and 'common fund' and other similar doctrines shall not be applied to reduce the right of assignment or reimbursement." *Rodriguez v. Tennessee Laborers Health & Welfare Fund*, 87 Fed. Appx. at 956.

REASONS FOR ALLOWING THE WRIT

As maintained in the Court of Appeals (Appellant's Brief, pp. 31-32, Appx. G), a split among the circuits on whether the "make-whole" rule from the law of commercially-

sold insurance policies makes impossible the establishment of a mandated *uniform* law on ERISA interpretation, *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), except by decision of this Court settling this important issue of law.

Some circuits have rejected or indicated probable disapproval of the doctrine that the insurance "make-whole" rule is a part of ERISA law, *Harris v. Harvard Pilgram Health Care, Inc.,* 208 F.3d 274 (1 Cir., 2000), *Waller v. Hormel Foods Corp.,* 120 F.3d 138 (8 Cir., 1997), and *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst,* 102 F.3d 1368 (5 Cir., 1996). Cases opposed, by their adoption of this insurance rule as applicable to ERISA plans in differing degrees, include *Copeland Oaks v. Haupt,* 209 F.3d 811 (6 Cir., 2000), *Cagle v. Bruner,* 112 F.3d 1510 (11 Cir., 1997) and the earliest of such decisions, *Barnes v. Ind. Auto. Dealers Ass'n. of Calif. Health & Ben. Plan,* 64 F.3d 1389 (9 Cir., 1995).

Those Courts of Appeal rejecting the insurance law "make whole" doctrine point to the insurance rule's inconsistency with ERISA, which is normally supplemented in proper instances by consideration of the federal common law of trusts. As opposed to this, none of the Courts of Appeal adopting the insurance doctrine attempt to establish the validity of their unspoken basic premise that ERISA contemplates the common law relating to insurance policies will be applicable to interpretation of an ERISA health fund's provisions.

As always, the judicial enunciation of previously

unrecognized principles leads to problematic secondary questions—as here, the determination that the applicability of the judicially developed "make whole" doctrine must be set out in the summary plan description required by 29 U.S.C. § 1022 and/or the assignment/subrogation agreement signed by plaintiff in addition to the detailed plan document required by 29 U.S.C. § 1024 where the exclusionary language appears. Thus, some Circuits require ERISA plans to use sophisticated text from judicial decisions in their various documents, so that it was contended (Appellant's Brief, pp. 33-36, Appx. G) that the statutory requirement of summary contents in 29 U.S.C. § 1022 did not include the mandate to make a summary statement about judicially-adopted doctrines such as "make whole," because lay persons such as plaintiff cannot be expected to understand why the doctrine was created by the judiciary, much less why the doctrine was conclusively disavowed by an ERISA plan.

Congressional enactment makes uniform ERISA interpretation a nationally-important subject. Hence, the resolution of this conflict among the circuits through issuance of the writ and decision by this Court is the only way the content of that uniform law can be established.

Perhaps equally important—possibly even somewhat *more* important—is the second question, as to whether an appellate court is **obligated,** not merely empowered, to follow the law when a party claims to have respectfully demonstrated that the decision (or authority which appears to justify it) is

itself contrary to law. This issue does not present any conflict among the Circuits. With the procedural rules inviting litigants to point out when an appellate court's decision has "overlooked or misapprehended" the law, Rule 40, F.R.App.P. or that it "conflicts with a decision of the United States Supreme Court", Rule 35, F.R.App.P., modern word-search research methods indicate that the response of every Circuit Court of Appeals on this point is total silence.

Hence it appears that in the entire history of the United States of America, there has never been a judicial decision from *any* appellate court, including this Court, on whether the obligation to decide in accordance with law imposes a **duty** upon the appellate court, upon receipt of a serious rehearing petition proving that its decision was contrary to law, to correct its opinion so it will conform to law, as distinguished from a mere prerogative of the Court to follow the law if this pleases the Court.

The laws of logic and rules of reason have been known from ancient times, and are constantly applied by all people, even many of comparatively low intelligence. The vital importance of the accuracy of the basic premise to rational rhetoric has long been understood, as have been the most common logical fallacies. Every Federal appellate judge is capable of understanding and following these rules of reason.

Petitioner suggests that if the canons of statutory construction be applied to these promulgations of law in the Federal Rules of Appellate Procedure, with regard to the duties

of the *Federal* appellate judiciary, the force of the Constitution's Supremacy and Due Process Clauses (U. S. Const., Art. VI, ¶ 2, and Fifth Amendment), should lead to the conclusion that these rules impose duties upon Federal appellate judges, rather than granting them prerogatives.

While some Courts of Appeals have held that mere deference to a prior panel decision is adequate to bar further consideration of whether past decisions were supported or contradicted by the law, *Fulford v Klein,* 529 F2d 377 (5 Cir., 1976), *United States v Lewis,* 991 F2d 524 (9 Cir., 1993), the Court of Appeals for the Sixth Circuit has held, by panel decision, that a prior panel decision was not authoritative when shown to be contrary to law, *National Leadburners Health & Welfare Fund v. Kelley & Co.,* 129 F.3d 372 (6 Cir., 1997).[5]

This is a question that addresses itself to this Court's

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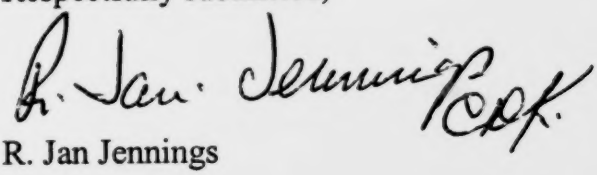
[5] "*Merriman* did not decide if a collective bargaining agreement negotiated by a multi-employer association that was not signed by an individual employer may satisfy LMRA § 302's "written agreement" requirement. . . .

Because we are not constrained by previous decisions in this circuit as the district court thought, an inquiry as to the possibility of a statutory signature requirement begins with the statute. Absent ambiguity or a result that is demonstrably at odds with legislative intent, statutory provisions must be accorded their plain meaning. *Nixon v. Kent County, 76 F.3d 1381, 1386 (6th Cir. 1996).* (129 F.3d, at 374-375; emphasis added).

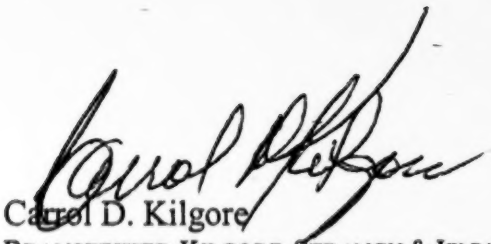
supervisory jurisdiction and which merits a thorough exposition in at least one opinion by it. If such an opinion by this Court were published, it is likely that many petitions for *Certiorari* would no longer be needed. There is a great gulf, both in essence and in appearance, between the result-oriented decision, made philosophically, emotionally, or however, which clutches at straws for its support, and the decision laboriously arrived at by discerning and obeying the requirements of the law, as described by Chief Justice Marshall in *Osborne v. Bank of the United States,* 22 U.S. 738, 6 L.Ed. 204 (1824).

Petitioner recognizes that the most any litigant can realistically expect of any judge is a genuine attempt to follow the law in every decision; but it is also submitted that this is the *least* that the American people should deem acceptable performance by any judge. Without regard to whether legal conflicts over a point of law have raged within the bench and bar, this second question, equally with the first, is one on which the Court should opine, and on which its opinion should receive the unanimous agreement of all its justices.

Respectfully submitted,



R. Jan Jennings



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Appendix A

Opinion of the Court of Appeals

ELIAS RODRIGUEZ, Plaintiff-Appellee, v. TENNESSEE LABORERS HEALTH & WELFARE FUND, Defendant-Appellant.

No. 02-5601

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

2004 U.S. App. LEXIS 2067

February 6, 2004, Filed

NOTICE: [*1] NOT RECOMMENDED FOR FULL-TEXT PUBLICATION. SIXTH CIRCUIT RULE 28(g) LIMITS CITATION TO SPECIFIC SITUATIONS. PLEASE SEE RULE 28(g) BEFORE CITING IN A PROCEEDING IN A COURT IN THE SIXTH CIRCUIT. IF CITED, A COPY MUST BE SERVED ON OTHER PARTIES AND THE COURT. THIS NOTICE IS TO BE PROMINENTLY DISPLAYED IF THIS DECISION IS REPRODUCED.

PRIOR HISTORY: ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE. 00-01003. Trauger. 04-30-02.

DISPOSITION: AFFIRMED.

LexisNexis (TM) HEADNOTES - Core Concepts:

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For TENNESSEE LABORERS HEALTH & WELFARE FUND, Defendant - Appellant: R. Jan Jennings, Carrol D. Kilgore, Branstetter, Kilgore, Stranch & Jennings, Nashville, TN.

JUDGES: BEFORE: BOGGS, Chief Circuit Judge; GIBBONS, Circuit Judge; and GWIN, District Judge. *

> * The Honorable James S. Gwin, United States District Judge for the Northern District of Ohio, sitting by designation.

OPINIONBY: James S. Gwin

OPINION:

JAMES S. GWIN, District Judge. The Tennessee Laborers Health and Welfare Fund ("Fund"), an ERISA plan administrator, appeals from a district court decision that found it had no right to reimbursement from participant Elias Rodriguez after Rodriguez **[*2]** settled a claim against a third-party tortfeasor. The Fund contends that Rodriguez had no coverage under the ERISA plan and that it erred in paying benefits on his behalf. Moreover, the Fund argues that it has a right to reimbursement from the settlement proceeds that Rodriguez received.

With this appeal, we examine whether the district court: (1) erred when it determined that the Fund construed an ERISA plan provision in an arbitrary and capricious manner; (2) erred when it determined that the Fund was not entitled to reimbursement based on the federal common-law "make whole" rule; and (3) erred when it denied the Fund's motion to alter, amend, or reconsider an interlocutory order.

For the following reasons, we AFFIRM the district court's decisions on all issues the Fund raises in its appeal.

HISTORY

In July 1997, Rodriguez began work for Skilton Paving and Construction Company ("Skilton"). Skilton contributes to the Fund's employee welfare benefit plan governed by the Employee Retirement Insurance Security Act (ERISA), *29 U.S.C. § 1001 et seq.* In October 1997, Rodriguez sustained an on-the-job injury that left him unable to work for Skilton. Following **[*3]** this injury, Skilton continued to pay Rodriguez wages, to document Rodriguez as a full-time employee, and to submit contributions to the Fund on behalf of Rodriguez. At the time, the Fund was unaware that Rodriguez no longer worked for Skilton.

On April 4, 1999, Rodriguez suffered serious injuries in an automobile accident unrelated to his work. Before paying any medical benefits under the plan, the Fund required Rodriguez to sign a subrogation agreement. On June 8, 1999, Rodriguez' wife signed this agreement on Rodriguez' behalf.

Shortly thereafter, Rodriguez requested that the Fund waive any right to subrogation of any recovery he received from a third-party tortfeasor. Rodriguez argued that such limits to insurance coverage would result in his not being fully compensated for his injuries and damages. Rodriguez later

informed the Fund's Board of Trustees that he would recover approximately $ 116,666 through settlements of his claims.

As of November 30, 1999, the Fund had paid approximately $ 238,638.11 in medical expenses on behalf of Rodriguez. At a March 6, 2000, meeting of the Fund's Board of Trustees, the Board reviewed Rodriquez' request that it not seek reimbursement. The **[*4]** Board unanimously decided to reduce its reimbursement demand to $ 57,139.94.

Rodriguez requested the Board reconsider its decision. At its May 22, 2000, meeting, the Board again discussed Rodriguez' request. For the first time, the Board considered whether Rodriguez had been entitled to receive any benefits for his injuries sustained in the April 4, 1999, accident. After this May 22, 2000, review, the Board determined that Rodriguez was not an employee covered under the Fund's plan at the time of the April 4, 1999, automobile accident because he had not worked at Skilton since October 1997. The Board interpreted the "CONTINUATION OF ELIGIBILITY" section of the benefits plan to require that an employee work 130 hours per month to maintain eligibility for benefits. Although the Board gave suggestions regarding how Rodriguez might purchase coverage under COBRA, n1 the Board demanded subrogation of $ 57,139.94 that Rodriguez would receive from the third-party tortfeasor.

n1 The Consolidated Omnibus Budget Reconciliation Act (COBRA), codified in ERISA at *29 U.S.C. § 1161 et seq.*

[*5]

Rodriguez did not make the payments and instead brought suit under ERISA, *29 U.S.C. § 1132(a)(3)*, in the United States

District Court for the Middle District of Tennessee. With his complaint, Rodriguez sought a declaration of his rights under the terms of the plan. Rodriguez asked the district court to find that he was eligible to receive benefits in April 1999 and to prevent the Fund from seeking reimbursement from the settlement recovery. After ordering the Fund to supplement the administrative record with plan documents and amendments in effect from October 1, 1997, through April 30, 1999, the district court entered an interlocutory order. With its order, the district court granted Rodriguez judgment regarding his eligibility for coverage under the plan and the applicability of the common law "make whole" rule to the plan. The Plan subsequently conceded that Rodriguez' recovery had not made him whole, which was the only remaining issue in the case. The Fund moved for reconsideration of the order entering judgment for Rodriguez, and the district court denied that motion. The Fund then filed a timely notice of appeal.

STANDARD OF REVIEW

We review *de novo* **[*6]** a district court's grant of judgment in an ERISA action. *Wilkins v. Baptist Healthcare Sys. 150 F.3d 609 (6th Cir. 1998)*. When an ERISA plan expressly grants a Fund discretionary authority to interpret plan provisions, we review the Fund's interpretation of the provisions under the arbitrary and capricious standard of review. *See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989)*; *Hunter v. Caliber Sys., Inc., 220 F.3d 702, 711 (6th Cir. 2000)*; *Yeager v. Reliance Standard Life Ins. Co., 88 F.3d 376, 380 (6th Cir. 1996)*; *Cooper Tire & Rubber Co. v. St. Paul Fire & Marine Ins. Co., 48 F.3d 365, 371 (8th Cir. 1995)* (applying arbitrary and capricious standard to a claim brought under *29 U.S.C. § 1132(a)(3)*). Review under the arbitrary and capricious standard is the least demanding form of judicial review of an

administrative action. Under this standard of review, "we must decide whether the plan administrator's decision was 'rational in light of the plan's provisions.'" *Smith v. Ameritech, 129 F.3d 857, 863 (6th Cir. 1997)* (quoting **[*7]** *Daniel v. Eaton Corp., 839 F.2d 263, 267 (6th Cir. 1988).*

In contrast, this court reviews the district court's denial of the Fund's motion for reconsideration of an interlocutory order for abuse of discretion. District courts possess the authority and discretion to reconsider and modify interlocutory judgments any time before final judgment. *See, e.g., Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp., 460 U.S.1, 12, 74 L. Ed. 2d 765, 103 S. Ct. 927 (1983)* (noting that "every order short of a final decree is subject to reopening at the discretion of the district judge"); *Mallory v. Eyrich, 922 F.2d 1273, 1282 (6th Cir. 1991).* Because district courts have broad discretion in this area, we review such decisions under the deferential abuse of discretion standard. *See, e.g., Amer. Canoe Assn, Inc. v. Profl Paddlesports Assn, 326 F.3d 505, 514-15 (4th Cir. 2003).* This court, however, treats the district court's interpretation and application of the Federal Rules of Civil Procedure as a question of law and reviews the district court's analysis *de novo. Jalapeno Prop. Mgmt., LLC v. Dukas, 265 F.3d 506, 510 (6th Cir. 2001).* **[*8]**

ANALYSIS

A. Interpretation of Plan Provision

On appeal, the Fund argues that its determination that the health benefits plan covered Rodriguez only when he worked 130 hours in a given month was neither arbitrary nor capricious. Since Rodriguez did not work at Skilton after October 1997, the Fund contends that Rodriguez was not a covered employee at the time of his accident in April 1999.

The plan's CONTINUATION OF ELIGIBILITY section

states that an employee "will continue to be eligible [for benefits] so long as one or more contributing Employers shall have paid on his behalf funds representing at least 130 hours of work."

The parties disagree on whether "representing at least 130 hours of work" required that Rodriguez work 130 hours per month to maintain benefit coverage. When read in context of the entire plan, the Fund contends that the phrase means that an employee must work 130 hours per month to maintain coverage. On the other hand, Rodriguez suggests that the phrase merely required Rodriguez employer to continue to pay an amount equivalent to at least 130 hours of work per month to the Fund. If this Court finds, the provision ambiguous, Rodriguez argues that the Court **[*9]** must construe it in his favor in light of *University Hospitals of Cleveland v. Emerson Electric Co., 202 F.3d 839, 846-47, 849 (6th Cir. 2000)* (quoting *Perez v. Aetna Life Ins. Co., 150 F.3d 550, 557 n.7*) (noting in dicta that if an ERISA plan provision is susceptible to more than one reasonable interpretation, the court will construe ambiguities against the drafting party under the rule of *contra proferentem*).

The language of a benefit plan is ambiguous if it is subject to more than one reasonable interpretation. *See Wulf v. Quantum Chem. Corp., 26 F.3d 1368, 1376 (6th Cir. 1994).* Here, we find no ambiguity since the plain meaning of the contested provision supports only Rodriguez' interpretation. Therefore, we need not decide the applicability of the rule of *contra proferentem.*

General rules of contract interpretation guide us in construing the Fund's plan. *See Hunter, 220 F.3d at 712.* Under such rules, we interpret the disputed plan provision according to its plain meaning. *See Williams v. Int'l Paper Co., 227 F.3d*

706, 711 (6th Cir. 2000).

Restating, the plan provision reads:

> **[*10]** SECTION 3 - CONTINUATION OF ELIGIBILITY:
> Once having become eligible, a Covered Employee will continue to be eligible so long as one or more contributing Employers shall have paid on his behalf funds representing at least 130 hours of work for each Contribution Month which corresponds with the respective Benefit Month.

The straightforward reading of this contested provision shows the unreasonableness of the Fund's interpretation. Webster's Dictionary defines "representing" as "standing in the place of." Webster's Dictionary 1926 (3d ed. 1993). To "represent" something is specifically *not* to require the presence of the thing itself. Therefore, the Fund's interpretation that "representing at least 130 hours of work" is equivalent to "working at least 130 hours" does not accord the phrase its plain meaning and is therefore unreasonable. Moreover, the Fund's reading of the provision renders the word "representing" superfluous. *See Restatement (Second) of Contracts § 203(a) (1981)* ("An interpretation which gives a reasonable, lawful, and effective meaning to all the terms is preferred to an interpretation which leaves a part unreasonable, **[*11]** unlawful, or of no effect.").

The INITIAL ELIGIBILITY section also shows the Fund's interpretation of the provision was not reasonable. In the INITIAL ELIGIBILITY section, the plan clearly requires an employee to work before the employee is eligible for benefits. The plan's INITIAL ELIGIBILITY section reads as follows:

> An employee shall become initially eligible on the

> first day of the second month following the month in which he has been in the employ of a contributing Employer or Employers and worked at least 260 hours for which contributions are due the Fund during a period not exceeding four (4) consecutive months.

This language stands in stark contrast to the "representing" language found in the CONTINUATION OF ELIGIBILITY section. The INITIAL ELIGIBILITY section unambiguously states that an employee must have worked before benefit eligibility starts. In contrast, the CONTINUATION OF ELIGIBILITY section states that benefits can continue if a contributing employer continues to pay funds "representing" hours of work for the employee. If the plan had intended that a plan participant must actually work to continue to receive benefits, it could have patterned the CONTINUATION **[*12]** OF ELIGIBILITY section after the language used in the INITIAL ELIGIBILITY section. Yet, the plan chose to diverge from the clear work requirement found in the INITIAL ELIGIBILITY section in its CONTINUATION OF ELIGIBILITY section. We find the Fund's argument unpersuasive that such strikingly different language describes the same work requirement.

The potential implications that arise from the Fund's interpretation of the provision also suggest that the Fund's interpretation is unreasonable. For example, the Fund's interpretation of the provision could conflict with the Federal Medical Leave Act of 1993 ("FMLA"), *29 U.S.C. § 2601 et seq.* n2 While this potential conflict is not determinative, it further suggests that the Fund's interpretation is unreasonable. Furthermore, the Fund's interpretation fails to account for vacation, medical, or personal leave. As the district court noted, requiring that an employee work 130 hours in a given month to

maintain coverage would result in termination of coverage when an employee took a vacation or medical leave that caused the employee to work less than 130 hours in a month. This result might or might not be illegal. **[*13]** It is, however, not reasonable.

> n2 The Fund disputes that Rodriguez was eligible for coverage under the FMLA. We need not decide whether Rodriguez qualified for FMLA protection. Instead, we decide if the Fund's interpretation, an interpretation that would deny coverage to many employees taking advantage of the FMLA, is reasonable. The discussion of the FMLA merely highlights one of many instances in which the Fund's interpretation could result in an unreasonable elimination of coverage.

The Fund contends that additional plan provisions support its interpretation of the disputed provision. Specifically, the Fund relies on the INITIAL ELIGIBILITY section, the HOUR BANK section, and the SELF-CONTRIBUTION RULES section. The Fund argues that the plan as a whole supports only its interpretation of the contested provision. *See United States Fid & Guar. Co. v. Ins. Co. of N. Am., 1998 U.S. App. LEXIS 11761, No. 95-5954, 1998 WL 321054 at *2 (6th Cir. June 2, 1998)*(stating that in interpreting a plan provision, the document should **[*14]** be read as a whole). We disagree with the Fund's argument. None of the provisions cited by the Fund convinces us of the reasonableness of the Fund's interpretation of the CONTINUATION OF ELIGIBILITY section. In fact, each section is inapplicable or otherwise supports Rodriguez' interpretation of the disputed provision in equal force.

As previously discussed, the INITIAL ELIGIBILITY section outlines the eligibility requirements for beginning

participation in the plan. Although this provision requires a plan participant to have worked before initial coverage begins, the provision does not suggest that a plan participant must work to continue coverage. Moreover, we have already noted that this section supports Rodrguez' interpretation of the debated provision since it clearly shows that the plan knew how to draft a provision requiring work for continued coverage, if that had been the Fund's intent.

The HOUR BANK section allows a plan participant to accumulate excess hours to satisfy the minimum contribution requirement if the participant's employer fails to make the required contribution. This section does not apply in Rodriguez' situation where his employer submitted the necessary **[*15]** contributions to continue Rodriguez' coverage. Furthermore, the HOUR BANK provision demonstrates that an employee can maintain coverage other than by working 130 hours during a contribution month.

The SELF CONTRIBUTION RULES section sets forth a means by which a plan participant continues coverage by contributing the payments necessary for 130 hours. The Fund suggests that this section provides the exclusive way that coverage can continue when a participant fails to work for an employer. However, this section seriously undercuts the Fund's argument that an employee must work 130 hours per month for continued eligibility. As with the situation in Rodriguez' case, the SELF CONTRIBUTION RULES allow coverage to continue although the employee has not worked 130 hours in the previous month. Thus, this section directly contradicts the Plan's proposed interpretation of the disputed provision.

No ambiguity exists in the contested provision. Rodriguez' employer paid contributions to the fund equivalent to the amount paid for a full-time worker. Thus the employer "paid on

his behalf funds representing at least 130 hours of work." The plain meaning of the plan language and the document taken **[*16]** as a whole make no requirement that an employee work to continue to receive benefits. For the above reasons, we affirm the district court's finding that Rodriguez was a covered employee at the time he received medical benefits.

B. "Make Whole" Rule

Even if we find Rodriguez to be a covered employee, the Fund urges us to reverse the district court's determination that the "make whole" rule bars the Fund's claim for subrogation or reimbursement from Rodriguez. The Fund concedes that Rodriguez was not "made whole" by his recovery. However, the Fund argues that the Plan sufficiently disavows application of the "make whole" rule. The Fund seeks subrogation or reimbursement under the following provision:

> **Reimbursement / Assignment**
>
> In the event of any payment under this Plan, the Trustees shall be subrogated to all the rights of recovery thereof of either a Covered Employee or a Covered Dependent against any person or entity, and the Covered Employee or Covered Dependent shall execute and deliver instruments and papers and whatsoever else is necessary to secure such rights. Neither the Covered Employee or the Covered Dependent shall do anything after a loss to prejudice such **[*17]** rights, *and common law doctrines such as 'make whole' and 'common fund' or other similar doctrines shall not be applied to reduce the right of assignment or reimbursement*
>
> If requested in writing by the Trustees, the

Covered Employee or Covered Dependent shall take, through any representative designated by the Trustees, such action as may be necessary or appropriate to recover such payment as damages from any person or entity, said action to be taken in the name of the Covered Employee or the Covered Dependent. In the event of a recovery or settlement, the Trustees shall be reimbursed out of such recovery or settlement for expenses, costs and attorneys' fees incurred by them in connection therewith. The right is hereby given the Trustees to receive from any third part(ies), attorneys(s) or insurance compan(ies) an amount equal to the amount paid on behalf of the Covered Employee or Covered Dependent.

The Trustees shall be entitled to the extent of any payment made to a Covered Employee or Covered Dependent, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of any Covered Employee or Covered Dependent against any person **[*18]** or entity legally responsible for the injury, sickness or condition for which such payment was made.

While the Plan expects full reimbursement for all benefits paid on behalf of the Covered Persons, there may be occasional circumstances in which full reimbursement is not possible. In such cases, the Plan will expect reimbursement to the extent of the Covered Person's recovery, except that the Covered Person may deduct from this amount and retain any out-of-pocket expenses he or she may have incurred for medical expenses as well as

> *other actual and reasonably incurred losses as may be documented to and reviewed by the Trustees. Any deduction for out-of-pocket medical expenses and other out-of-pocket expenses must be fully documented.*

1999 Plan Document (emphasis added). n3

> n3 The Fund adopted the 1999 plan after Rodriguez' accident on April 4, 1999. The prior 1985 plan did not include the italicized language. Rodriguez urges us to use the 1985 plan. The district court, however, based its decision on the 1999 plan. The parties did not address the issue of which plan should govern at the district court level. Neither does the Fund raise the issue in its brief. Consequently, we do not now consider the issue on appeal. *See United States v. Crozier, 259 F.3d 503, 517 (6th Cir. 2001)* (noting that a court generally will not hear issues raised for first time in reply brief); *see also Pinney Dock & Transp. Co. v. Penn. Cent. Corp., 838 F.2d 1445, 1461 (6th Cir. 1988)* (stating that we will not consider on appeal an issue not discussed by the district court, unless "the issue is presented with sufficient clarity and completeness"). **[*19]**

On appeal, the Fund states that another source of its right to subrogation or reimbursement comes from the Subrogation Agreement signed by Rodriguez' wife. The Subrogation Agreement provides:

> In the event I receive directly the proceeds of any judgment, settlement or other recovery in connection with a legal claim for damages related to the above claim, I hereby agree that the Fund

> shall be entitled to such proceeds to the extent that it paid benefits for that claim and that I will pay over to the Fund such amount. I agree that the Fund may recover such amount by offset against future benefits or through any other reasonable and lawful method.

The "make whole" rule of federal common law "provides that an insurer cannot enforce its subrogation rights unless and until the insured has been made whole by any recovery." *Copeland Oaks v. Haupt, 209 F.3d 811, 813 (6th Cir. 2000)* (quoting 16 Couch on Insurance 2d § 61:64). In *Copeland Oaks,* this Court held that the "make whole" rule applies to a subrogation clause in an ERISA plan. We allowed, however, for a plan to avoid the application of the "make whole" rule by including language conclusively disavowing **[*20]** the rule's application to the plan. Specifically, we required that the plan be "clear in establishing both a priority to the funds recovered and a right to any full or partial recovery." *Id.* n4 We later made clear that the "make whole" rule applies to reimbursement as well as subrogation clauses. *Hiney Printing Co. v. Brantner, 243 F.3d 956 (6th Cir. 2001).*

n4

> Hence, we now hold that in order for plan language to conclusively disavow the default rule, it must be specific and clear in establishing both a priority to the funds recovered and a right to any full or partial recovery. In the absence of such clear and specific language rejecting the make-whole rule--with clarity and specificity ultimately determined by the reviewing court--it is

> arbitrary and capricious for a plan administrator not to apply the default.
>
> *Copeland Oaks, 209 F.3d at 813*

The Fund's subrogation agreement signed on behalf of Rodriguez does not properly disavow the "make whole" rule. The [*21] agreement does not establish who has priority to any recovered amounts nor whether the Fund has a right to full or partial recovery. Under *Copeland Oaks* and *Hiney,* this agreement gives the Fund no basis for asserting its right to reimbursement or subrogation against Rodriguez.

Neither does the 1999 Plan conclusively disavow the default rule of *Copeland Oaks.* The Fund argues that the 1999 Plan language negating application of the "make whole" rule meets the disavowal requirements of *Copeland Oaks* and *Hiney.* Although the 1999 Plan states that the "make whole" doctrine does not apply, the 1999 Plan does not establish who has priority to any recovered funds or whether the Plan has a right to full or partial recovery. *See Copeland Oaks, 209 F.3d at 813.* Absent such language, the 1999 Plan has not sufficiently disavowed the "make whole" doctrine.

The 1999 Summary Plan Description also fails to disavow the "make whole" rule. The 1999 Summary Plan Description reads:

> **Subrogation**
>
> In the event of any payment under this Plan, the Trustees shall be subrogated to all the rights of recovery thereof of either a Covered Employee or a Covered Dependent against **[*22]** any person or entity, and the Covered Employee or Covered Dependent shall execute and deliver instruments

and papers and whatsoever else is necessary to secure such rights. Neither the Covered Employee or the Covered Dependent shall do anything after a loss to prejudice such rights.

If requested in writing by the Trustees, the Covered Employee or Covered Dependent shall take, through any representative designated by the Trustees, such action as may be necessary or appropriate to recover such payment as damages from any person or entity, said action to be taken in the name of the Covered Employee or the Covered Dependent. In the event of a recovery or settlement, the Trustees shall be reimbursed out of such recovery or settlement for expenses, costs and attorneys' fees incurred by them in connection therewith. The right is hereby given the Trustees to receive from any third part(ies), attorneys(s) or insurance compan(ies) an amount equal to the amount paid on behalf of the Covered Employee or Covered Dependent.

The Trustees shall be entitled to the extent of any payment made to a Covered Employee or Covered Dependent, to the proceeds of any settlement or judgment that may **[*23]** result from the exercise of any rights of recovery of any Covered Employee or Covered Dependent against any person or entity legally responsible for the injury, sickness or condition for which such payment was made.

1999 Summary Plan Description.

Like the 1999 Plan, the 1999 Summary Plan Description fails to establish who has priority to the funds or the Fund's right to any full or partial recovery as required by *Copeland Oaks*. Thus, the 1999 Summary Plan Description does not satisfactorily disavow application of the "make whole" rule. n5

> n5 Plaintiff Rodriguez argues that even if the 1999 Plan disavowed the "make whole" doctrine, the Court should hold that the summary plan description is binding over the plan itself. For support, Plaintiff relies on *Edwards v. State Farm Mut. Auto. Ins. Co., 851 F.2d 134, 136 (6th Cir. 1988)*. This was, in fact, the rationale for the district court's decision on the applicability of the "make whole" rule. This Circuit has, however, expressly refused to extend *Edwards* to omissions of details:
>
> > The principle announced in *Edwards* does not apply to silence. An omission from the summary plan description does not, by negative implication, alter the terms of the plan itself. The reason is obvious: by definition, a summary will not include every detail of the thing it summarizes.
> > *Sprague v. GMC, 133 F.3d 388, 401 (6th Cir. 1998)* (*en banc*) (citations omitted).
>
> Because we find that the 1999 Plan fails to disavow the "make whole" rule, we need not decide whether the omission of the 1999 plan language from the 1999 summary plan description is the sort of silence which results in application of *Sprague*. **[*24]**

Because the Subrogation Agreement, the 1999 Plan, and the 1999 Summary Plan Description do not satisfactorily disavow the "make whole" rule under *Copeland* and *Hiney*, the district

court properly found that the "make whole" doctrine barred the Fund from seeking any subrogation or reimbursement from Rodriguez. We affirm the district court's decision on this point.

C. Motion for Reconsideration

The Fund also complains that the district court erred in denying its motion for reconsideration of an interlocutory order. In support of the district court's authority to hear such motions, the Fund points to *Federal Rule of Civil Procedure 54(b)*. The Fund suggests that a district court may deny such a motion only if the movant filed it in bad faith as defined by *Federal Rule of Civil Procedure 11(b)(1)-(4)*. The Fund asks this Court to hold that the district court erroneously analyzed the issue by considering factors that are normally considered when a party seeks relief from a final judgment.

In its motion for reconsideration, the Fund urged the district court to consider as evidence Skilton's collective **[*25]** bargaining agreement. The Fund contended that the bargaining agreement clarified that the plan language required Rodriguez to work 130 hours per month to remain eligible for medical benefits. The Fund further argued that the district court should not have relied on the potential illegality of the plan provision under the FMLA because it was an "illusory" illegality.

Concluding that the collective bargaining agreement had been in existence at the time of the earlier order and could have been introduced into to the record at that time, the district court found no reason for subsequently considering the agreement. In addressing the Fund's FMLA argument, the district court noted that the Fund misconstrued its reasoning. Even if the district court accepted the Fund's FMLA argument, the district court noted that its findings would remain the same. The district court then denied the Fund's motion for reconsideration.

The Federal Rules of Civil Procedure do not explicitly

address motions for reconsideration of interlocutory orders. Because of this, some circuits have suggested that a district court's power to reconsider an order before final judgment exists under federal common law, not **[*26]** the Federal Rules of Civil Procedure. *See, e.g., City of Los Angeles v. Santa Monica Baykeeper, 254 F.3d 882, 886 (9th Cir.2001).* Although we agree that the authority for hearing such motions has a common law basis, we find additional support in *Federal Rule of Civil Procedure 54(b). See Fayetteville v. Commercial Builders, Inc., 936 F.2d 1462, 1469-70 (4th Cir. 1991)* (approving of *Rule 54(b)* as a proper procedural vehicle for bringing motions to reconsider interlocutory orders).

District courts have authority both under common law and *Rule 54(b)* to reconsider interlocutory orders and to reopen any part of a case before entry of final judgment. *See Mallory, 922 F.2d at 1282.* This authority allows district courts "to afford such relief from [interlocutory orders] as justice requires." *Citibank (South Dakota), N.A. v. FDIC, 857 F. Supp. 976, 981 (D.D.C. 1994); see also Melancon v. Texaco, Inc., 659 F.2d 551, 553 (5th Cir. 1981).* Traditionally, courts will find justification for reconsidering interlocutory orders when there is (1) an intervening change of controlling law; **[*27]** (2) new evidence available; or (3) a need to correct a clear error or prevent manifest injustice. *Reich v. Hall Holding Co., 990 F. Supp. 955, 965 (N.D. Ohio 1998).* n6

> n6 This standard obviously vests significant discretion in district courts. However, this and not *Rule 11* is the standard governing requests for reconsideration of interlocutory orders. A movant has no right to reconsideration of an interlocutory order simply because the movant makes the motion in good faith.

Here, the district court set forth general guidelines to help determine whether justice required that it reconsider its interlocutory order. n7 Since the Fund had the evidence at the time of the court's earlier decision, the district court's refusal to consider this evidence is not clearly unjust. Further, justice does not require that the district court allow the Fund an opportunity to make a legal argument on an issue that would not alter the district court's prior decision. Therefore, we find no abuse of discretion in the **[*28]** district court's order denying the motion for reconsideration of the interlocutory order.

n7 The district court stated that it "generally will consider motions for reconsideration pursuant to the grounds available for motions to alter or amend under *Rule 59(e)* or upon a showing that the court clearly overlooked material facts or controlling law that was presented by the party in its prior motion and that would result in a different disposition." *See Al-Sadoon v. FISI*Madison Fin. Corp., 188 F. Supp. 2d 899, 902 (M.D. Tenn. 2002)*. We do not interpret this language as stating that motions for reconsideration of interlocutory orders are governed by the standards of either *Rule 59* or *Rule 60*. The district court merely appeared to give litigants guidance on when it would generally find that justice required the granting of a motion for reconsideration.

CONCLUSION

For the foregoing reasons, we AFFIRM the district court on all issues raised for appeal by the Appellant-Defendant.

Appendix B

Interlocutory Opinion of the District Court

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

ELIAS RODRIGUEZ,	)	
	)	**Case No.**
Plaintiff,	)	**3:00-1003**
	)	
v.	)	**JUDGE**
	)	**TRAUGER**
TENNESSEE LABORERS HEALTH AND WELFARE FUND	)	

MEMORANDUM

Pending before the court are the plaintiff's Motion to Vacate Decision of Plan Administrator (Docket No. 32) and the defendant' s Motion for Judgement (Docket No. 17) brought pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1001-1461.[1] For the reasons discussed herein, the plaintiff's motion will be **GRANTED** in part and **DENIED** in part, and the defendant's

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[1]Although this action was brought against several def defendants, all defendants other than the Tennessee Laborers Health and Welfare Fund have been dismissed by previous order or stipulation (Docket Nos. 31, 36)

motion will be **DENIED**.

I. STATEMENT OF FACTS

In or around July 1997, the plaintiff began working for Skilton Paving and Construction company ("Skilton"). Skilton is a party to a collective bargaining agreement requiring contributions to the Tennessee Laborers Health and Welfare Fund ("the Fund"). After the plaintiff had worked the requisite number of hours for Skilton and the Fund received from Skilton the requisite contributions on the plaintiffs behalf, the plaintiff became eligible to receive benefits from the Fund.

In approximately October 1997, the plaintiff sustained an on-the-job injury that left him unable to perform work for Skilton. Following this injury, Skilton continued to pay the plaintiff compensation, document the plaintiff as a full-time employee, and submit contributions to the Fund on behalf of the plaintiff, enabling him to maintain his health coverage.

On April 4, 1999, the plaintiff was severely injured in an automobile accident. Prior to paying any benefits under the plan, the Fund required the plaintiff to sign an agreement entitled "Tennessee Laborers Health and Welfare Fund Subrogation Agreement" ("Subrogation Agreement"). (Docket

No. 11, Affidavit of Jere T. Brassell, Jr., para. 12[2]; *id.*, attach. Ex. 1, Administrative Record (hereinafter "Admin. Record") at 181-82) The plaintiff's wife signed this agreement on behalf of the plaintiff on or about June 8, 1999. (Admin. Record at 182) As of November 30, 1999, the Fund had paid approximately $238, 638.11 in medical expenses on behalf of the plaintiff.

By letter dated June 7, 1999, the plaintiff requested that the defendant waive any right to subrogation of his recovery against third parties on the ground that any such recovery would be limited to the extent of available insurance coverage

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[2]According to Brassell's affidavit, the Plan Document and the Summary Plan Description require the execution of the Subrogation Agreement prior to the payment of benefits under the plan. (Docket No. 11, Brassell Aff, para. 12) Although both the Plan Document and the Summary Plan Description state that "the Covered Employee or Covered Dependent shall execute and deliver instruments and papers and whatsoever else is necessary to secure [assignment or reimbursement] rights" (Admin. Record at 107, 165), there is nothing in these provisions that specifically requires the plan participant to execute the Subrogation Agreement prior to the payment of any and all benefits under the plan. However, it is undisputed that the Fund did require the plaintiff to execute the Subrogation Agreement and that the plaintiff's wife, acting under a power of attorney, did execute and date the Subrogation Agreement on June 8, 1999. (Admin. Record at 182)

and would not compensate the plaintiff fully for his injuries. (Admin. Record at 195) By letter dated November 3, 1999, the plaintiff informed the Board of Trustees that he would recover approximately $116,666 through settlement of his claims against third parties, which was the maximum amount available under the various insurance policy limits. (Admin. Record at 205)

At a March 6, 2000 meeting of the Board of Trustees of the Fund, the Board reviewed the plaintiffs request for waiver of subrogation rights and unanimously "determined that it would be appropriate to split the gross recovery to Mr. Rodriguez, less the amount of the Cigna/Medicare lien, evenly between Mr. Rodriguez and the fund. As a result, the fund's subrogation entitlement was reduced to $57, 139.94." (Admin. Record at 187)

The plaintiff sought reconsideration of this decision at the May 22, 2000 meeting of the Board of Trustees, (Admin. Record at 188) During their reconsideration of the plaintiff's request, the Board considered the newly-raised issue of the plaintiffs eligibility to receive any benefits at all under the plan. The Board determined that the plaintiff was not a covered employee under the plan because he had not been working at Skilton since his on-the-job injury in October 1997. Although Skilton had continued to submit contributions on the plaintiff's behalf, the Board found that this was improper because the plaintiff was not actually working at Skilton at the time.

The Board held that Skilton's contributions on behalf of the plaintiff should be returned and that the plaintiff should be given the opportunity to make the necessary contributions to re-

instate his eligibility under the plan. The Board determined that the plaintiff could become an eligible employee through January 1, 2000 by making self-contribution payments under the plan and then by extending his plan coverage under the terms of the Consolidated Omnibus BudgetReconciliation Act ("COBRA"), codified in ERISA at 29 U.S.C. § 1161 *et seq.* If the plaintiff made these contributions, totaling $585 in self-contributions and $4,418.26 in COBRA payments, then the Board would seek reimbursement of only the $57,139.94 it had agreed upon previously. In the event the plaintiff did not make the necessary contributions, the Board unanimously directed the administrator to seek a recovery from the various service providers of claims paid on behalf of Mr. Rodriguez during the period of time when he was not eligible, including those for the injury by the third party, and to notify the service providers that those claims should have been processed and paid by Medicare, as after Mr. Rodriguez was ineligible

for benefits from the fund, Medicare would be solely responsible for the payment of claims.

Id. at 191. The plaintiff did not make the requested payments and instead brought this lawsuit, seeking to clarify his status and rights under the ERISA plan.

II. STANDARD OF REVIEW

On October 24, 2000, the plaintiff brought this suit seeking declaratory judgment and equitable relief under the Employee

Retirement Income Security Act of 1974("ERISA"), as amended, 29 U.S.C. § 1001-1461. Specifically, the Complaint states:

> Pursuant to 29 U.S.C. § 1132(a)(1)(B) and 29 U.S.C. § 1 132(a)(3),
>
> Plaintiff seeks equitable relief, including, but not limited to, a declaration
>
> of rights under the Plan, against Defendants to establish Plaintiff's rights
>
> to his third-party recovery without having to reimburse Defendants, to
>
> seek a determination as to Plaintiff's rights to past and future benefits, to
>
> enforce ERISA and the terms of the Plan and to collect attorney fees for
>
> Plaintiff's attorney under ERISA.

(Docket No. 1, para. 21) The plaintiff further requests that the court make the following declarations:

> (1)As of October, 1997, Plaintiff was an Eligible Employee under the Plan and, since that time,

has remained an Eligible Employee under the Plan because Skilton Construction has paid, on behalf of Plaintiff, funds representing at least 130 hours of work for each

Contribution Month which corresponds with the respective Benefit Month.

(2)
The Plan's Subrogation provision does not specifically disclaim the make-whole rule as required by the Sixth Circuit's decision in *Copeland Oaks v Haupt,* 209 F.3d 811 (6th Cir. 2000).

(3)

Plaintiff was not made whole by the $116,667.00 settlement.

(4)
The Trustees were arbitrary and capricious in seeking 100% subrogation from a participant based upon a plan provision that did not disclaim the make-whole rule.

Id., para. 22.

Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), the United States Supreme Court held that "a denial of benefits challenged under § 11

32(a)(l)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.*, at 115, 109 S .Ct. at 956-57. If such discretion does exist in the plan, then the administrator's decision must be reviewed under the more deferential "arbitrary and capricious" standard. *See Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 555 (6th Cir. 1998) (en bane).

The plaintiff's claims in this case are not for the denial of benefits, because the defendant has already paid medical expenses on his behalf. *See Allinder v. Inter-City Prods. Corp.*, 152 F.3d 544, 550-51 (6th Cir. 1998) (finding that "[s]ection 1132(a)(1)(B)'s provisions concerning the recovery of benefits wrongfully denied are not applicable in this case because [the plaintiff] eventually did receive the benefits she was entitled to under ICP's policy"). Although the plaintiff initially brought his claims under both section 1 132(a)(l)(B) and section 1132(a)(3), in his motion to vacate the decision of the plan administrator, he characterizes his claims as arising under section 1132(a)(3) "to enforce the terms of an employee benefit plan." (Docket No. 34)

Section 1132(a)(3) allows for civil actions by a participant "(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3). Section 1132(a)(1)(B), by comparison, allows for civil actions by a plan participant "to

recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(l)(B).

The plaintiff seeks both a declaration that he was eligible to receive benefits under the plan in April 1999 and to prevent the defendant from seeking reimbursement from the proceeds of the settlement with the third-party tortfeasors. Because the defendant believes that the plaintiff was not entitled to any benefits under the plan, it has not filed a counterclaim for reimbursement from the settlement proceeds. Instead, the defendant states in its memorandum that "[t]he Health Fund is in the process of obtaining repayment from providers. . . ." (Docket No. 18 at 16) The plaintiff is not seeking compensatory damages only injunctive and other equitable relief. It is possible to construe the plaintiff's claim regarding his eligibility as seeking either to enforce his rights under the terms of the plan or to enforce the terms of the plan.

Similarly, the plaintiff's claim regarding the defendant's right to reimbursement could be construed as either seeking to enforce his rights under the terms of the plan or to enjoin an act that violates the terms of the plan. What is clear is that the plaintiff is not appealing the denial of benefits under the plan.

The question, then, is whether the *Firestone* standard applies in cases either brought

under section 1132(a)(I)(B) and not involving the denial of benefits or brought under some other provision of ERISA. In *Firestone,* the Supreme Court clearly stated that "[t]he discussion which

follows is limited to the appropriate standard of review in § 1132(a)(1)(B) actions challenging denials of benefits based on plan interpretations. We express no view as to the appropriate standard of review for actions under other remedial provisions of ERISA." *Firestone,* 489 U.S. at 108, 109 S.Ct. at 953. In that discussion, however, the Court found that "[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers. A trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed if reasonable." *Id.,* at 111, 109 S.Ct. at 954 (internal citations omitted).

The applicability of *Firestone* to claims other than for the denial of benefits was addressed by the Sixth Circuit in *Hunter v. Caliber Sys., Inc.,* 220 F.3d 702 (6th Cir. 2000). The court rejected the plaintiff's contention that *Firestone* could be applied only in denial-of-benefits claims and found "no barrier to application of the arbitrary and capricious standard in a case such as this not involving a typical review of denial of benefits." *Id.* at 711. Other circuits have applied the *Firestone* standard in cases similar to this one. *See, e.g.,*

Cagle v. Bruner, 112 F.3d 1510, 1516 (11th Cir. 1997) (applying the standard, by agreement of the parties, in a case challenging the ability of the plan administrator to condition the payment of benefits on the execution of a subrogation agreement); *Cooper Tire & Rubber Co. v. St. Paul Fire and Marine Ins. Co.,* 48 F.3d 365, 371 (8th Cir. 1995) (applying *Firestone* to a claim brought under section 1132(a)(3)). In this case, the same trust principles discussed in *Firestone* lead to the conclusion that the arbitrary and capricious standard should be applied if the plan grants discretion to the Trustees to interpret its provisions.

As the Sixth Circuit has noted, "[t]he Court in *Firestone* . . . did not suggest that "discretionary authority" hinges on incantation of the word "discretion" or any other "magic word." *Johnson v. Eaton Corp.,* 970 F.2d 1569, 1572 n.2 (6th Cir, 1992) (quoting *Block v. Pitney Bowes Inc.,* 952 F.2d 1450, 1453 (D.C.Cir. 1992)). Yet, "[w]hile 'magic words' are unnecessary to vest discretion in the plan administrator and trigger the arbitrary and capricious standard of review, this circuit has consistently required that a plan contain 'a *clear* grant of discretion [to the administrator] to determine benefits or interpret the plan.'" *Perez,* 150 F.3d at 555 (quoting *Wulf Quantum Chem. Corp.,* 26 F.3d 1368, 1373 (6th Cir. 1994)) (emphasis in original); *see also Yeager v Reliance Standard Life Ins. Co.,* 88 F.3d 376, 380 (6th Cir. 1996)

(finding that the Sixth Circuit requires "that the plan's grant of discretionary authority to the administrator be 'express") (citations omitted).

Both the 1985 Plan Document and the 1999 Plan Document provide that "[t]he Trustees have full authority to

construe the provisions of this Plan and any construction placed upon the Plan by the Trustees shall be final and binding upon all parties." (Admin. Record at 107; Supp. Admin. Record at 54) This is a clear grant of discretion to the Trustees. Thus, under *Firestone,* the arbitrary and capricious standard of review should be applied to the Trustees' interpretations of the plan provisions. Regardless of the standard applied, however, the defendant's interpretations of the ERISA plan fail upon review. Thus, even if the *Firestone* standard is not appropriate in this case and the *de novo* standard of review should be employed, the court would reach the same conclusions. As a result, the court will employ the arbitrary and capricious standard of review to the plaintiffs claims.

Under the "deferential 'arbitrary and capricious' standard, [the court] will uphold a [plan interpretation] if it is 'rational in light of the plan's provisions.'" *Univ. Hospitals of Cleveland Emerson Elec, Co.,* 202 F.3d 839, 846 (6th Cir. 2000), *reh'g and reh'g en banc denied* (March 3, 2000) (quoting *Yeager v. Reliance Standard Life Ins. Co.,* 88 F.3d 376, 381(6th Cir. 1996) (internal quotations and citation omitted)). "A decision is not arbitrary and capricious if it is based on a reasonable interpretation of the plan." *Shelby Co. Health Care Corp. v. Southern Council of Indus. Workers Health and Welfare Trust Fund,* 203 F.3d 926, 933 (6th Cir. 2000). However, a plan administrator must discharge its duties with respect to the plan 'in accordance with the documents and instruments governing the plan.' *McMillan v. Parrott,* 913 F.2d 310, 311 (6thCir. 1990) (quoting 29 U.S.C. § 1104(a)(1)(D)). In interpreting the provisions of a plan, a plan administrator must adhere to the plain meaning of its language, as it would be construed by an ordinary person.

Id. at 934.

As to the posture of the parties' motions, the defendant presents its motion under the procedure established in *Wilkins v. Baptist Healthcare Sys., Inc.,* 150 F.3d 609, 619 (6th Cir. 1998). The plaintiffs motion, entitled Motion to Vacate Decision of Plan Administrator, does not address either the proper procedure or the standard of review to be employed by the court. In *Wilkins,* the Sixth Circuit found that the following steps should be employed when evaluating an ERISA action:

> 1 As to the merits of the action, the district court should conduct a review based solely upon the administrative record, and render findings of fact and conclusions of law accordingly. The district court may consider the parties' arguments concerning the proper analysis of the evidentiary materials contained in the administrative record, but may not admit or consider any evidence not presented to the administrator.
>
> 2 The district court may consider evidence outside of the administrative record only if that evidence is offered in support of a procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part. This also means that any prehearing discovery at the district court level should be limited to such procedural challenges.

Id.

The parties appear to agree that the court's analysis is limited to a review of the administrative record, which is proper under ERISA. For the purposes of determining the plaintiff's eligibility for benefits as of April 1999 and the applicability of the common law make-whole doctrine to the defendant's right to reimbursement of medical expenses paid on behalf of the plaintiff, there is no need to consider evidence outside of the administrative record. As will be discussed, *infra,* further evidence is needed before the court can determine whether the plaintiff was made whole by the payment of medical expenses by the defendant and the receipt of approximately $116,000 in settlement from the third-party tortfeasors. Aside from this determination, however, the court will comply with the *Wilkins* procedure and will limit its role to a review of the administrative record.[3]

III. ANALYSIS

There are two separate issues before the court. First, the plaintiff challenges the defendant's finding that he is not a covered employee and, therefore, not entitled to benefits under the ERISA plan. Second, the plaintiff challenges the defendant's right to reimbursement for medical expenses paid on his behalf under the plan.

[3]The initial administrative record submitted by the defendant contained the Trust Agreement, the Restatement, Amendment and Continuation of Self-Funded Plan Document, effective May 1, 1999, and the summary plan description effective May 1, 1999. (Docket No. 11, Affidavit of Jere T. Brassell, Jr., attach. Ex. 1) Because the defendant determined that the plaintiff's eligibility under the plan ceased in or around October 1997 and the plaintiffs accident occurred April 4, 1999, it was necessary for the court to verify that the relevant provisions of the Plan Document remained unchanged from 1997 forward. Therefore, the court ordered the defendant to submit plan documents and amendments in effect from October 1, 1997 through April 30, 1999. (Docket No. 41) These documents are contained in the Supplemental Administrative Record, which the court will consider as part of the administrative record. (Docket No.42, Supp. Affidavit of Jere T. Brassell, Jr., attach. Ex. 1)

A. Was Rodriguez a Covered Employee in April 1999?

The defendant argues that the plaintiff was not an eligible employee under the plan as of October 1997 when he ceased working at Skilton. Although Skilton continued to pay the plaintiff as a full-time employee and to make full contributions to the Fund on his behalf, the defendant argues that the plan requires the plaintiff actually to have worked at least 130 hours per month in order to be eligible to receive

benefits. The parties agree that the plaintiff was covered under the plan prior to his on-the-job injury in October 1997. Hence, the question is whether the plaintiff's eligibility continued after he ceased working in October 1997.

> The Plan Documents were restated on April 1, 1985 and again on May 1, 1999. (Docket

No. 42, Supplemental Affidavit of Jere T. Brassell, Jr., attach. Ex. 1 ("Supp. Admin. Record");

Admin. Record at 54) The latest amendment to the relevant provision of the 1985 Plan

Document occurred as of January 1, 1993. Under this amendment, the Continuation of

Eligibility provision states:

> Once having become eligible, a Covered Employee will continue to be
>
> eligible so long as one or more contributing Employers shall have paid on
>
> his behalf funds representing at least 130 hours of work for each
>
> Contribution Month which corresponds with the

respective Benefit Month.

(Supp. Admin. Record at 106) This provision remained unchanged in the May 1, 1999 restatement of the Plan Document. (Admin. Record at 75) The plaintiff argues that this provision allows employers to contribute funds to the Fund on behalf of employees who have not actually worked 130 hours in a given month, as long as the funds *represent* 130 hours of work.

The defendant claims that relying on this provision alone is illogical and constitutes an "unrealistically narrow view of how a reasonably prudent employee would read and review this important document." (Docket No. 37 at 4 (quoting *Sharron v. Amalgamated Ins. Agency Serv.,*

Inc., 704 F.2d 562, *565* (11th Cir. 1983)) instead, the defendant relies on two other provisions of the Plan Document and related documents as supporting its interpretation that an employee must actually work 130 hours per month in order to be eligible to receive benefits under the plan.

First, the defendant relies on the introductory sentence of Article IV - Rules of Eligibility, which states that "[a]ny person *working for a contributing Employer* or Employers within the jurisdiction of the Tennessee Laborers Health and Welfare Fund shall be eligible to receive benefits and will become a Covered Employee after satisfying the following

requirements: (Supp. Admin. Record at 22) (emphasis supplied by defendant)

Second, the defendant excerpts the following language from a document entitled Revised Statement of Employer Contributions Collections and Payroll Auditing Procedures - Tennessee Laborers Health and Welfare Fund: "Employer reporting forms and corresponding contributions due the Fund for *hours worked by plan participants* during the respective month of employment (work month) must be submitted to the Fund office or the Fund's designated depository no later than the 10th day of the following month (first month)." (Admin. Record at *175-76)* (emphasis supplied by defendant) This document was executed by the Board of Trustees on February 12, 1990, under the authority of Article VI: Contributions and Collections of the Agreement and Declaration of Trust, which provides that "[t]he Trustees shall establish a uniform system among the Employers for the timely transmission of contributions and such reports, as the Trustees deem necessary, to the Fund office, and shall also establish a periodic date on which such reports and contributions shall be due." *Id.* at 38; *see also id.* at 175.

The defendant argues that the italicized sections of these provisions indicate that an

employee must actually work the requisite number of hours in order to continue to be eligible for

benefits under the plan.[4] Because the plaintiff did not work after his on-the-job injury in October 1997, the defendant claims that he was not an eligible employee at the time of the April 1999 accident.

"General rules of contract interpretation incorporated as part of the federal common law of contract interpretation guide [the court] in construing an EMSA plan." *Hunter v. Caliber Sys., Inc.*, 220 F.3d 702, 712 (6th Cir. 2000). These rules "dictate that [the court] interpret the provisions according to their plain meaning in an ordinary and popular sense. In applying the 'plain meathng' analysis, [the court] 'must give effect to the unambiguous terms of an ERISA plan." *Williams v. Int'l Paper Co.*, 227 F.3d 706, 711(6th Cir. 2000), *reh 'g and reh 'g en banc denied* (Oct. 31, 2000) (quoting *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550,556(6th Cir. 1998) (quoting *Lake v. Metropolitan Life Ins. Co.*, 73 F.3d 1372, 1379 (6th Cir. 1996))).

In this case, the plaintiff relies on the language of the provision within Article IV - Rules of Eligibility entitled Continuation of Eligibility. Utilizing plain meaning analysis, the court must agree that this is the proper provision to consider in determining whether the plaintiff continued to be eligible for Fund benefits after his initial eligibility was established.

Under general contract principles, the court cannot rely on the general language of the introductory statement to Article IV in lieu of the specific language of Section 3 of that Article relating to the continuation of eligibility. *See, e.g.,*

[4]The defendant also makes repeated references to the collective bargaining agreement between the employers and employees. (Docket No. 18 at 4-3; Docket No. 37 at 3-4) No collective bargaining agreement was submitted as part of the Administrative Record, and the defendant has offered no excerpts from the collective bargaining agreement in support of its position. As a result, the court has no basis for relying on the collective bargaining agreement as establishing anything relevant to this issue. The court must and shall rely on the Administrative Record submitted by the parties and the language of the Plan Document.

403, 413-14 (2nd Cir. 2001) (interpreting ERISA plan under federal common law contract principles and citing authorities)[5] *Landmark Land Co., Inc. v. Fed Dep. Ins. Corp.,* 256 F.3d 1365, 1376 (Fed. Cir. 2001), *reh'g and reh en banc denied* (Nov. *15,* 2001). Similarly, the court cannot rely on language not included in the Plan Document and not related to the rules of eligibility for benefits as establishing the proper interpretation of this provision.

As a result, the court is left solely with the language of the Continuation of Eligibility provision, stating that eligibility continues as long as the employer makes contributions to the Fund "representing at least 130 hours of work for each Contribution Month" for each plan participant. The defendant argues that it is reasonable to

interpret this language as requiring 130 hours of actual work by each plan participant each month. The plaintiff argues that the plan requires contributions on behalf of each employee in an amount equal to the amount that would be submitted if the employee worked 130 hours, but there is no requirement that the employee actually work 130 hours each month in order to maintain eligibility.

The language "representing 130 hours of work" is ambiguous; hence, the court must only determine whether the defendant's interpretation of that provision is reasonable. *See Shelby Co. Health Care Corp. v. Southern Council oflndus. Writs. Health and Welfare Trust Fund,* 203 F.3d 926, *935* **(6th Cir. 2000) (holding that, although a** plan administrator who has discretion under

[5]As the Second Circuit noted, it is a thndamental rule of contract construction that 'specific terms and exact terms are given greater weight than general language.' RESTATEMENT (SECOND) OF CONTRACTS § 203(c) (1981). Even where there is no 'true conflict' between two provisions, 'specific words will limit the meaning of general words if it appears from the whole agreement that the parties' purpose was directed solely toward the matter to which the specific words or clause relate.' 11 Richard A. Lord, Williston on Contracts § 32.10, at 449 (4th ed. 1999).

Aramony, 254 F.3d at 4 13-14 (internal citations omitted).

and ERISA plan is granted "great leeway in interpreting ambiguous terms," the "plan administrator's interpretation of ambiguous provisions must. be reasonable") (quoting *Moos v. Square D. Co.*, 72 F.3d 39,42 (6th Cir. 1995)). However, even where an arbitrary and capricious standard of review is employed, "to the extent that the Plan's language is susceptible of more than one interpretation, [the court] will apply the 'rule of *contra proferentum* 'and construe any ambiguities against. the drafting parties." *Univ. Hospitals of Cleveland v. Emerson Elec. Co.*, 202 F.3d 839, 846-47 (6th Cir. 2000), *reh'g and reh'g en banc denied* (March 3, 2000) (citing *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 557 n.7 (6th Cir. 1998)) (noting this as one limitation on the arbitrary and capricious standard of review in interpreting ERISA plan). In *Perez,* the Sixth Circuit noted that "[t]he rule of *contra proferentum* provides that ambiguous contract provisions in ERISA-govened insurance contracts should be construed against the drafting party. The rule of *contra proferentum,* however, only applies to *ambiguous* contract provisions. Ambiguity requires two reasonable interpretations," *Perez,* 150 F.3d at *557* n.7 (internal citations omitted) (emphasis in original). Thus, the court must determine whether the interpretations advanced by the parties are reasonable.

Other principles of contract interpretation guide the court in this decision. "Under settled principles of construction, [a] contract must be read as a whole so as to give meaning and effect to all of its provisions." *Divers Uied Energy, Inc. v. Tennessee Valley Auth.*, 223 F.3d 328, 339 (6th Cir. 2000) (quoting *Malone & Hyde, Inc. v. United States,* 568 F.2d 474, 476 (6th Cir.1978)). The contract's "terms must be construed so as to render none nugatory and

avoid illusory promises." *Int'l Union UAWv. Yard-Man, Inc.*, 716 F.2d 1476, 1480 (6th Cir. 1983). Thus, "an interpretation which gives a reasonable, lawful, and effective meaning to all the terms is preferred to an interpretation which leaves a part unreasonable, unlawful, or of no effect."

RESTATEMENT (SECOND)OF CONTRACT'S
§ 203(a) (1981).

One of the other provisions under the Rules of Eligibility states that employees may maintain their eligibility for benefits by making self-contributions where their employers have not contributed for 130 hours of work in a given month. (Supp. Admin. Record at 106) If an employee's continued eligibility required that he or she actually work at least 130 hours per month, then there could be no allowance for self-contribution for employees who failed to work that number of hours. The defendant responds that it requires that an employee either work 130 hours per month *or* make self-contributions accounting for the difference. (Docket No. 18 at 14) Of course, that interpretation requires the concession that "representing 130 hours of work" does not require 130 hours of actual work by an employee. Hence, the question becomes whether self-contribution is the only method by which an employee who

does not work 130 hours in a given month may maintain health coverage under the plan.

Although not addressed by either party, another consideration aids in this analysis. If the defendant's interpretation of the provision is accepted, then there is no allowance in the Plan Document for employees to take vacations, medical or maternity leave, or personal leave, without either risking the loss of health coverage or requiring self-contribution to maintain the coverage.[6] No reasonable interpretation of the ER.ISA plan would result in such a finding. More importantly, this interpretation would not accommodate leave taken pursuant to the Family and Medical Leave Act of 1993 ("FMLA"), 29 U.S.C. § 2601, *et seq.* Under section 2614(c) of the

[6]The defendant may argue that the collective bargaining agreement accounts for these issues. However, as noted, the collective bargaining agreement is not part of the Administrative Record in this case. The court must interpret the language of the Plan Document, and the Plan Document does not contain any allowance for these activities without the risk of loss of coverage.

FMLA,

> during any period that an eligible employee takes leave under section 2612 of this title, the employer shall maintain coverage under any 'group health plan' for the duration of such leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave.

Interpreting the Plan Document as stating that the only way for an employee who has not actually worked 130 hours in a given month to maintain eligibility under the plan is to self-contribute the difference would mean that the plan was in violation of the FMLA.

The court cannot and does not assume that the defendant has intended or effected such a result.[3] Nonetheless, that would be the effect of the defendant's interpretation of the Plan Document. As the United States Supreme Court has held, "[s]ince a general rule of construction presumes the legality and enforceability of contracts, 6A A. Corbin, Contracts §§ 1499, 1533 (1962), ambiguously worded contracts should not be interpreted to render them illegal and unenforceable where the wording lends itself to a logically acceptable construction that renders them legal and enforceable." *Walsh v. Schlecht,* 429

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[3] The defendant has evidenced its concern for compliance with other federal laws, including the Labor Management Relations Act, also known as the Taft Hartley Act, 29 U.S.C. § 185, *et seq.,* in making its argument. (Docket No. 37 at 4)

U.S. 401, 408, 97 SQ. 679, 685, 50 L.Ed. 2d 641 (1977). In this case, a logically acceptable construction of the Continuation of Eligibility provision is that continued eligibility requires contributions "representing 130 hours of work," without requiring 130 hours of actual work each month. Thus, employees who take vacations or FMLA leave would not be required to self-contribute in order to maintain their eligibility, and there would be no violation of the FMLA.

The defendant's interpretation of the Plan Document is not reasonable because it does not

account for approved, paid leave by employees and because it would result in a violation of the FMLA. Because the defendant's finding that the plaintiff was not an eligible employee in April 1999 is based on an unreasonable interpretation of the plan, it is arbitrary and capricious. *See Shelby Co. Health Care Corp.*, 203 F.3d at 933 ("A decision is not arbitrary and capricious if it is based on a reasonable interpretation of the plan.").

Even if the court were to find that the defendant's interpretation is reasonable, the plaintiff's interpretation of the

Continuation of Eligibility provision is equally reasonable. As a result, there is, at most, an ambiguity, and ambiguous provisions must be construed against the drafting party. *See Univ. Hospitals of Cleveland,* 202 F.3d at 846-47. The defendant drafted the Plan Document, so the plaintiffs interpretation of the ambiguous provision must be accepted. Under the plaintiffs interpretation of the Continuation of Eligibility provision, the defendant's determination that the plaintiff was not a covered employee in April 1999 is arbitrary and capricious. The defendant admits that Skilton paid full contributions on behalf of the plaintiff from October 1997 through April 1999, while the plaintiff was on paid medical leave for an on-the-job injury. This is all that is required for continuation of the plaintiffs eligibility for benefits.

Because the court finds that the plan administrator's decision regarding the plaintiffs eligibility for benefits in April 1999 was arbitrary and capricious, the decision must be vacated. Under the Plan Document, the plaintiff was eligible for benefits under the plan at the time of the April 4, 1999 accident. Hence, the plaintiff is entitled to coverage for any medical expenses that would have been paid by the Fund under the terms of the plan as a result of that accident.[4]

Judgment will be granted in favor of the plaintiff with regard to his eligibility for coverage under the ERISA plan through April 4, 1999.

B Defendant's Right to Subrogation or Reimbursement under the Plan

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Because the court has found that the plaintiff was an eligible employee in April 1999, it is necessary to resolve the second issue presented by the parties, namely, the enforceability of the subrogationireimbUrsement provision of the ERISA plan. It is undisputed that the plaintiff brought claims directly against the third parties liable for the Apnl 1999 accident and received the settlement benefits from the respective insurance policies. As a result, there is no issue of subrogation in this case, only of reimbursement.[5]

Although the defendant had expended more than $230,000 for medical expenses on behalf of the plaintiff by the end of 1999, the defendant seeks reimbursement of only $57,139.94 of that amount, or one half of the settlement proceeds received by the plaintiff. The plaintiff objects to any reimbursement on the ground that the federal common law make-whole doctrine precludes the defendant from seeking reimbursement where the plaintiff was not fully compensated for his injuries by third-party tortfeasors.

Unlike the Continuation of Eligibility provision, the reimbursement/Assignment provision of the Plan Document was affected by the May 1, 1999 Restatement, Amendment, and Continuation of the Self-Funded Plan Document. In the

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[5] Any eligibility or coverage issues that arose subsequent to that time must be reviewed initially by the Fund.

1985 Plan Document, Section 11 of Article VI,[6] entitled Subrogation,[7] stated:

In the event of any payment under this Plan, the Trustees shall be subrogated to all the rights of recovery thereof of either a Covered Employee or a Covered Dependent against any person or entity, and the Covered Employee or Covered Dependent shall execute and deliver instruments and papers and whatsoever else is necessary to secure such rights. Neither the Covered Employee or the Covered Dependent shall do anything after a loss to prejudice such rights.

> If requested in writing by the Trustees, the Covered Employee or Covered Dependent shall take, through any representative designated by the Trustees, such action as may be necessary or appropriate to recover such payment as damages from any person or entity, said action to be taken in the name of the Covered Employee or the Covered Dependent. In the event of a recoveryor settlement, the Trustees shall be reimbursed out of such recovery or settlement for expenses, costs and attorneys' fees incurred by them in connection therewith. The right is hereby given the Trustees to receive from any third party(ies), attorney(s)

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[6] *See Marshall v. Employers Health Ins. Co.,* 1997 WL 809997, at *5(6th Cir. 1997) (unpublished) (discussing the distinctions between subrogation and reimbursement).

[7] This provision remained unamended until the May 1, 1999 Restatement and Amendment, as reflected in the Supplemental Administrative Record

or insurance company(ies) an amount equal to the amount paid on behalf of the Covered Employee or Covered Dependent.

The Trustees shall be entitled to the extent of any payment made to a Covered Employee or Covered Dependent, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of any Covered Employee or a Covered Dependent against any person or entity legally responsible for the injury, sickness or condition for which such payment was made.

(Supp. Admin. Record at 54) By comparison, the May 1, 1999 Plan Document retitles Section 11 as Reimbursement/Assignment and provides:

In the event of any payment under this Plan, the Trustees shall be entitled to an assignment or reimbursement concerning all the rights of recovery thereof of either a Covered Employee or a Covered Dependent against any person or entity, and the Covered Employee or Covered Dôpendent shall execute and deliver instruments and papers and whatsoever else is necessary to secure such rights. Neither the Covered Employee nor the Covered Dependent shall do anything after a loss to prejudice such rights, *and common law doctrines such as 'make whole' and 'common fund' or other similar doctrines shall not be applied to reduce the right of assignment or reimbursement.*

If requested in writing by the Trustees, the Covered Employee or Covered Dependent shall take,

through any representative designated by the Trustees, such action as may be necessary or appropriate to recover such payment as damages from any person or entity, said action to be taken in the name of the Covered Employee or the Covered Dependent. In the event of a recovery or settlement, the Trustees shall be reimbursed out of such recovery or settlement for expenses, costs and attorneys' fees incurred by them in connection therewith. The right is hereby given the Trustees to receive from any third party(ies), attorney(s) or insurance company(ies) an amount equal to the amount paid on behalf of the Covered Employee or Covered Dependent.

The Trustees shall be entitled to the extent of any payment made to any Eligible Employee or Eligible Dependent, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of an Eligible Employee or an Eligible Dependent against any person or entity legally responsible for the injury, sickness or condition for which such payment was made.

While the Plan expects full reimbursement for all benefits paid on behalf of the Covered Person, there may be occasional circumstances in which full reimbursement is not possible. In such cases, the Plan will expect reimbursement to the extent of the Covered Person 's recovery, except that the Covered Person may deduct from this amount and retain any out-of-pocket expenses he or she may have incurred for medical expenses as well as other actual and reasonably incurred losses as may be documented to and reviewed by the Trustees. Any deduction for out-of-pocket medical expenses and other out-of-pocket expenses must

be fully documented.

(Admin. Record at 107-08) (emphasis added to highlight substantive changes)

In *Copeland Oaks v. Haupt,* 209 F.3d 811(6th Cir. 2000), *reh'g and reh'g en banc denied* (June 1, 2000), the Sixth Circuit explicitly adopted the federal common law make-whole doctrine with regard to subrogation provisions, a doctrine that had been applied previously in an unpublished case, *Marshall v. Employers Health Ins. Co.,* 1997 WL 809997 (6th Cir. 1997) (unpublished). "The make-whole rule provides that an insurer cannot enforce its subrogation rights unless and until the insured has been made whole by any recovery, including any payments from the insurer." *Copeland Oaks,* 209 F.3d at 814. As a default common law rule, parties may opt out of the make-whole doctrine by expressing a clear intent to do so. *See id,* at 813. However,

> in order for plan language to conclusively disavow the default rule, it must be specific and clear in establishing both a priority to the funds recovered and a right to any full or partial recovery. In the absence of such clear and specific language rejecting the make-whole rule - with clarity and specificity ultimately determined by the reviewing court - it is arbitrary and capricious for a plan administrator not to apply the default.
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> Id.

Although *Marshall* had considered both

subrogation and reimbursement provisions, the *Copeland Oaks* decision was limited to addressing the make-whole doctrine with regard to subrogation provisions. As a result, the defendant relies on the unpublished *Marshall* decision to support its argument that the reimbursement provision in this case is sufficient to preclude application of the default make-whole rule.

Although not addressed by either party, the court finds that this issue is governed by a more recent, published decision of the Sixth Circuit, *Hiney Printing Co. v. Bra ntner,* 243 F.3d 956 (6th Cir. 2001), *reh 'g en banc denied* (April 26, 2001). In *Hiney Printing,* the court found that

> [w]hile subrogation and reimbursement are distinct differences, we see no principled reason for treating them differently when it comes to the default application of the make-whole rule to ambiguous provisions. Indeed, the provision at issue in *Copeland Oaks,* while designated a subrogation clause, addressed both a right of subrogation and a right of reimbursement. Nor is the holding of *Copeland Oaks,* applying the make-whole rule to 'plan language' that was not 'specific and clear in establishing both a priority to the funds recovered and a right to any full or partial recovery,' restricted to subrogation clauses.

Id. at 959-60 (quoting *Copeland Oaks,* 209 F.3d at 813). The court then applied the *Copeland Oaks* standard to a

reimbursement provision that provided: "If the Plan member recovers damages from any party or through any coverage named above, he must hold in trust for the Employer the proceeds of the recovery, and must reimburse us to the extent of payment made."

Id. at 958. The court held that the reimbursement provision. . . fails to clearly establish that Hiney Printing's right to reimbursement applies to any full or partia recovery The provision merely obligates plan members to 'reimburse [the Benefit Plan] to the extent of payments made.' It thus fails to adequately inform Brantner that Hiney Printing could enforce this provision even if she had not been completely compensated for the financial expenses incurred as a result of her seriousmedical injuries. We therefore find the reimbursement provision ambiguous because it is silent as to whether the right of reimbursement applies to partial recovery, and accordingly, the make-whole rule applies.

Id. at 960.

Aside from changing the terms "Covered Employee" and "Covered Dependent" to "Eligible Employee" and "Eligible Dependent," respectively, both the 1985 and 1999 Plan Documents contain the following language regarding reimbursement:

> The Trustees shall be entitled to the extent of any payment made to a Covered Employee or Covered Dependent, to the proceeds of any settlement or judgment that may result from the exercise of any

> rights of recovery of any Covered Employee or a Covered Dependent against any person or entity legally responsible for the injury, sickness or condition for which such payment was made.

(Supp. Admin. Record at 54; Admin. Record at 107) This language is substantively indistinguishable from the language considered in *Hiney Printing* and held by the Sixth Circuit to be ambiguous regarding whether the right of reimbursement applies to partial recovery. Therefore, the federal common law make-whole doctrine must be applied to limit the defendant's right of reimbursement under this plan language.

> This determination, however, is not the conclusion of the court's analysis. The 199 Plan Document contains additional language that applies to both the subrogation and reimbursement provisions and states that "common law doctrines such as 'make whole' and 'common fund' or other similar doctrines shall not be applied to reduce the right of assignment or reimbursement." (Admin. Record at 107) Although *Marshall* allowed for conclusive disavowal of the makewhole doctrine, *see* 1997 WL 809997, at *4, neither *Copeland Oaks* nor *Hiney Printing* addressed whether such a general statement was sufficient to preclude application of the default

the rule. Assuming, *arguendo,* that this language is sufficient, the court must decide whether and, if so, to what extent the amendment in the 1999 Plan Document affects this case."

As noted previously, the 1985 Plan Document's subrogation provision was not amended prior to the 1999 Restatement and Amendment of the Plan Document, At the

time of the May 1, 1999 Restatement and Amendment, a new Summary Plan.Description ("SPD") was created and sent to plan participants. The Introduction to the SPD states that "[t]his booklet has been updated to inciude[] several changes which were made since your last booklet was printed." (Admin. Record at 113) The Subrogation provision in the SPD, however, is essentially identical to the

"Although a welfare benefits plan may be amended at any time, "benefits under a welfare benefit plan may vest under the terms of the plan itself." *Wheeler v. Dynamic Eng., Inc.*, 62 F.3d 634, 638 (4th Cir. *1995).* If the plaintiff's rights vested at the time of his accident on April 4, 1999, then the resolution of this issue must be based on the 1985 Plan Document. If, however, some or all of the plaintiff's rights were not vested until after May I, 1999, then the 1999 Plan Document may affect the defendant's right to reimbursement. Although the Sixth Circuit has not addressed this issue, other circuits have found that "[c]overage under a medical insurance policy or plan is normally triggered by one of two events. If a policy insures against illness, coverage for all medical costs arising from a particular illness vests when the illness occurs. If a policy insures against expenses, coverage vests when the expenses are incurred." *Id.; see also Member Sen's. Life Ins. Co. v. American Nat? Bank and Trust Co.,* 130 F.3d 950, 954 (10th Cir. 1997); *Cooper Tire & Rubber Co. v. St. Paul Fire and Marine Ins. Co.,* 48 F.3d *365,* 370 (8th Cir. *1995)* ("[The defendant] is bound by the terms of the Plan in effect at the time the [plaintiffs] incurred the covered medical expenses. After a covered event has occurred, a plan administrator cannot create new rights in a separate document and enforce those

rights under ERISA.").

The 1985 Plan Document provides the following definition for "Date Claim Incurred," a definition that is substantively unchanged in the 1999 Plan Document: "The incurred date of a claim for a Covered Employee or Covered Dependent is the first date on which the Covered Employee or Covered Dependent is under the care of a Physician andlor has incurred expense which is payable by the Fund for that particular disability." (Supp. Admin. Record at 13-14) Unfortunately, the plan contains no definition for "particular disability." In this case, the plaintiff suffered numerous injuries from a single accident, resulting in extensive, long-term treatment. It is unclear whether these injuries would be considered part of one "disability" caused by the accident or as separate events, claims for the treatment of which were incurred on separate dates.

This issue was neither raised nor addressed by either of the parties. However, because of the court's decision regarding the applicability of the 1999 Plan Document amendments to the subrogation/reimbursement provision, it is unnecessary to reach a conclusion on this issue.

Subrogation provision in the 1985 Plan Document. (Supp. Admin. Record at 54; Admin. Record at 165-66) The language highlighted previously to indicate the substantive changes in the 1999 Plan Document's ReimbursementlAssignment provision is conspicuously absent from the SPD.'[8]

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[8] In fact, not even/the technical changes, including changing "Covered" to "Eligible" with regard to employees and dependents, are included in the SPD.

There is no mention of the make-whole doctrine or any disavowal of it by the Fund.

The defendant argues that this language would be inappropriate in the SPD because it constitutes legalese, and ERISA specifically requires that summary plan descriptions be "written in a manner calculated to be understood by the average plan participant."[9] (Docket No. 37 at 5 (citing 29 U.S.C. §

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[9] Of course, the Sixth Circuit does not require any reference to the make-whole doctrine itself Instead, the plan language must provide that the plan has priority to any funds recovered by the participant from a third party and that the plan has the right to reimbursement of medical expenses paid by the plan even where the participant only partially recovers his or her damages from the third party. This is not "legalese" and could be incorporated easily into the SPD, simplify and explain a voluminous and complex document and then proclaim that any inconsistencies will be governed by the plan. Unfairness will flow to the employee for reasonably relying on the summary booklet." *Edwards,* 851 F.2d at 136 (quoting *McKnight v. Southern Life and Health Ins. Co.,* 758 F.2d 1566, 1570(11th Cir. 1985)). In this case, the conflict arises from the failure to include in the SPD a substantive change to the plan document. There is no evidence in the Administrative Record that the plaintiff received notice of the May 1, 1999 amendments to the Plan Document other than what was provided in the concurrent SPD.'[4] The SPD clearly provides no notice of any modification to the subrogation/reimbursement provision. Hence, the issue becomes whether a summary plan description that contains no indication of any modification to a provision is controlling over a Plan Document that has been modified.

1022(a)(1)) Instead, the defendant relies on the fact that the SPD informs plan participants that "[n]othing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan Document itself If there is any difference between the Plan Document and the summary in this booklet, the Plan Document will control." (Admin. Record at 163) The plaintiff, however, argues that "[t]he language of the Plan document. is not controlling since it conflicts with the summary plan description provided to Rodriguez. In fact, 'this 'Circuit has decided that statements in a summary plan are binding and if such statements conflict with those in the plan itself, the summary shall govern." (Docket No. 34 at 8 (quoting *Edwards v. State Farm Mut. Auto Ins. Co.,* 851 F.2d 134, 136 (6th Cir. 1988))

The plaintiff has stated correctly the principal holding of *Edwards,* As further noted in *Edwards,* "[i]t is of no effect to publish and distribute a plan summary booklet designed to

The facts of this case appear comparable to those before the Sixth Circuit in *He/wig v. Kelsey-Hayes Co.,* 93 F.3d 243 (6th Cir. 1996). As in *Helwig,* the plan participants here received only a copy of the SPD, not a copy of the 1999 Plan Document. *See id.* at 249. In *He/wig,* the court

considered whether the defendant had the right to modify or terminate vested benefits where no such provision was found in the SPD. The defendant argued that, because the master insurance agreements contained clauses providing for cancellation of the policy with due notice, and the summary plan description designated the master agreements as controlling, the right to modify or terminate the policies was reserved. *See id.* at 248-49.

"[4]Although not addressed by the parties, there is no reason to believe that the plan participants received a copy of the 1999 Plan Document, especially where the SPD states that "a copy of the Plan Document will be made available for your examination at the Fund Office or a copy of it will be reproduced for you at your request for a reasonable charge." (Admin. Record at 163) The Sixth Circuit made a similar finding in *Foltice v. Guardsman Prods., Inc.*, 98 F.3d 933, 938 (6th Cir. 1996), implicitly recognizing that distribution of the plan document along with the summary plan description is the exception, rather than the rule, with ERISA plans.

Even assuming that the cancellation clauses were applicable to modifications or terminations of benefits, the Sixth Circuit found that the district court had properly granted a preliminary injunction against the defendant's modifications. Considering "the plain language of the documents, the ERISA statute, and the legislative intent," the court held that

> [a]s to the reservation of the right to modify or terminate benefits, the legislative history.. weighs against allowing employers to promulgate SPDs which they can disavow even though ihey did not reserve such a right up front. Congressional intent cannot be carried out unless employers are required to adhere to the language of their own Summary Plan Descriptions. In *Edwards,* this Court refused to allow a Company to issue Summary Plan Descriptions which make all sorts of promises and then bury escape clauses in highly technical and inaccessible insurance agreements. Similarly, we cannot, in this case, permit the goals of the ERISA SPD provisions to be thus undermined..
>
> In this case, the SPDs promulgated by the Defendant made clear, unambiguous promises of lifetime coverage and they contained no valid provisions reserving the right to modify or terminate the benefits conferred. For these reasons, we hold that the plaintiffs have demonstrated a reasonable likelihood of success on the merits

Id. at 251.'

[5]*But see Sprague v. Gen. Motors Corp.,* 133 F.3d 388, 401 (6th Cir. 1998) (holding that the failure to state clearly in all summary plan descriptions that the company reserved the right to modify or terminate the plan "did not prejudice GM's right, clearly stated in the plan itself, to

change the plan's terms"). *Sprague* then held that "the principle announced in *Edwards* does not apply to silence. An omission from the summary plan description does not, by negative implication, alter the terms of the plan itself The reason is obvious: by definition, a summary will not include every detail of the thing it summarizes." *Id.* (internal citations omitted).

The *Sprague* court made no reference to the *Helwig* decision and did not attempt to reconcile its holding with that decision. Although it is true that the summary plan description will not include every detail of the plan itself, the SPDs are "produced under a statutory obligation of comprehensiveness and accuracy." *He/wig,* 93 F.3d at 250. lii this case, the 1999 SPD was intended to include the relevant amendments to the plan document, but it failed to inform the participants of the defendant's disavowal of a common law rule that substantially affects the defendant's ability to seek subrogation or reimbursement under the plan. As a result, the court cannot consider this mere silence on the issue and will rely on *Helwig.*

In this case, the SPD contained no indication that the defendant was disavowing the common law make-whole doctrine. The SPD reflected, almost verbatim, the language of the 1985 Plan Document, which is insufficient, under *Hiney Printing,* to preclude application of the make-whole doctrine. The Sixth Circuit allows for disavowal of the make-whole doctrine only when the intent to do so is clear and express, stating both a priority to recovered funds and a right of reimbursement whether or not there has been full recovery by the participant. The silence in the SPD regarding the defendant's disavowal of the make-whole

doctrine is misleading to the reasonable plan participant, especially in light of the fact that plan participants are not provided with copies of the Plan Document, To hold that the 1999 Plan Document language regarding the reimbursement provision is controlling over the 1999 SPD would undermine both the legislative intent of ERISA's requirements for summary plan descriptions and the Sixth Circuit's ruling that the make-whole doctrine must be applied unless there is clear and express language to the contrary.

Further, the Administrative Record contains a Subrogation Agreement signed on behalf of the plaintiff by his wife, acting under power of attorney. (Admin. Record at 182) The agreement is dated June 8, 1999, more than two months after the plaintiff's accident and more than a month after the 1999 Plan Document took effect. As with the 1999 SPD, the Subrogation Agreement was written by the defendant and does not contain any of the 1999 amendments to the subrogation/reimbursement provision of the Plan Document. In relevant part, the Subrogation Agreement provides:

> In the event I receive directly the proceeds of any judgment, settlement or other recovery in connection with a legal claim for damages related to the above claim, I hereby agree that the Fund shall be entitled to such proceeds to the extent that it paid benefits for that claim and that I will pay over to the Fund such amount. I agree that the Fund may recover such amount by offset against future benefits or through any other reasonable and lawful method.

(Admin. Record at 182) As with the 1985 Plan Document, under *Hiney Printing*, this language is insufficient to disavow the common law make-whole doctrine.

Thus, although the SPD had the same effective date as the 1999 Plan Document and the Subrogation Agreement was signed more than a month after that date, neither the SPD nor the Subrogation Agreement reflect the amended language of the reimbursement provision of the 1999 Plan Document the defendant cannot exempt itself from the common law make-whole doctrine merely by modifying the plan document, where it fails to inform the plan participants of that change by including the modification in the summary plan description and where it fails to include the exemption in the subrogation/reimbursement agreement that it required the plaintiff to sign in order to "secure [its] rights" to reimbursement. The SPD and the Subrogation Agreement are controlling, and neither clearly disavows the common-law make-whole doctrine under the standard established in *Hiney Printing* and *Cope/and Oaks.* As a result, the court need not decide whether the plaintiffs expenses were incurred prior to the May 1, 1999 plan amendment. The common law make-whole doctrine must be applied to limit the defendant's right of reimbursement against the plaintiffs recovery from third-party tortfeasors.

Although the parties agree that the Fund had paid more than $200,000 in medical expenses on behalf of the plaintiff by the end of 1999, there are no factual findings in the record regarding the total amount of benefits paid under

the plan on behalf of the plaintiff. The plaintiff received $116,000 in settlement proceeds from the third parties liable for the accident leading to the plaintiffs injuries. Under the make-whole doctrine, "an insurer cannot enforce its subrogation [or reimbursement] rights unless and until the insured has been made whole by any recovery, including any payments from the insurer."

The Administrative Record contains letters sent between the parties addressing the extent of the plaintiffs injuries and his expected inability to continue working. (Admin. Record at 195-272) Some of these letters reference attached medical summaries, outlines of the plaintiffs injuries and medical records, but these documents were not submitted as part of the Administrative Record. (Admjn. Record at 203-04, 210) As a result, the court is limited to letters from plaintiffs counsel stating that "Mr. Rodriguez will never work again and that his quality of life will never enable him to enjoy the work or recreation he once enjoyed. He generally walks with a cane, can hardly speak, and experiences constant pain." (Admin. Record at *205; see id.* at 231, *245)*

In *Copeland Oaks,* the Sixth Circuit remanded the case to the district court because "no court ha[d] ever made a specific factual finding regarding Brooke's total damages." *Cope/and Oaks,* 209 F.3d at 814. In *Hiney Printing,* by compa~son, the district court had made specific factual findings regarding whether the plaintiff had been made whole. *See Hiney Printing,* 243 F.3d at 960. In both cases, the courts were reviewing decisions on motions for summary judgment. As discussed, the plaintiff did not specify whether he was

moving for judgment under *Wilkins* or for summary judgment. Based on *Cope/and Oaks* and *Hiney Printing,* it is inappropriate for the court to limit its review of this issue to the Administrative Record as established in *Wilkins* as the proper practice in denial-of-benefits claims. Therefore, the court will deny the plaintiffs request for a declaration that he was not made whole by receipt of the settlement proceeds and by the payment of medical expenses by the Fund and will schedule an evidentiary hearing to address this issue.

IV. CONCLUSION

For the reasons discussed herein, the plaintiffs Motion to Vacate the Decision of the Plan Administrator (Docket No.32) will be GRANTED in part, and the defendant's Motion for Judgment (Docket No, 17) will be DENIED. Judgment will enter in favor of the plaintiff regarding his eligibility for coverage under the ERISA plan in April 1999 and regarding the application of the common law make-whole doctrine to the defendant's right of reimbursement under the plan. The plaintiffs motion will be DENIED as premature to the extent that it seeks a declaration that he was not made whole by his recovery of medical expenses and settlement proceeds. By separate order, the court will schedule an evidentiary hearing on the question of whether the plaintiff was made whole through this recovery.

An appropriate Order shall Enter.

Enter this 11th day of December 2001.

ALETA A. TRAUGER

United States District Judge

Appendix C

District Court's Order Overruling

Motion to Modify Interlocutory Order

[Rendered Final Judgment by Defendant's Admission on Record that Plaintiff had not been "made whole"]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

ELIAS RODRIGUEZ,	)	
	)	**Case No.**
Plaintiff,	)	**3:00-1003**
	)	
v.	)	
	)	
TENNESSEE LABORERS HEALTH AND WELFARE FUND,	)	**JUDGE TRAUGER**
	)	
	)	
Defendant.	)	
	)	

MEMORANDUM

Pending before the court is the defendant's Motion to Alter, Amend or Reconsider the Order of December 12, 2001 (Docket No. 46), to which the plaintiff has responded (Docket No. 56) and the defendant has replied (Docket No. 65). For the reasons discussed herein, the defendant's motion will be denied.

The facts have been stated in the prior Order of the court and are incorporated herein by reference. (Docket No. 43 at 1-4) The plaintiff brought this suit seeking declaratory judgment and equitable relief, including a declaration that he was an eligible employee under the ERISA plan through

April 1999, when he was injured in an automobile accident and sought benefits under the plan. (Docket No. 1, para. 21) On December 12, 2001, the court entered judgment in favor of the plaintiff regarding his eligibility for coverage in April 1999 under the defendant's ERISA plan. The court based its decision on the following provision of the plan, entitled Continuation of Eligibility:

Once having become eligible, a Covered Employee will continue to be eligible so long as one or more contributing Employers shall have paid on his behalf funds representing at least 130 hours of work for each Contribution Month which corresponds with the respective Benefit Month.

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(Docket No. 42, Supplemental Affidavit of Jere T. Brassell, Jr., attach. Ex. 1 ("Supp. Admin. Record") at 106)

In essence, the issue before the court was whether the phrase "representing 130 hours of work" required each employee actually to work 130 hours in each month in order to maintain eligibility. The court found this phrase ambiguous. (Docket No. 43 at 14) Thus, the defendant's interpretation that the employee was required to work 130 hours each month (or to self-contribute the difference) in order to maintain coverage would be upheld as long as it was reasonable. *See id.* at 8-9, 14-15.

The court found that the defendant's interpretation was not reasonable because it did not make any allowance for vacations or for medical, maternity, or personal leave. *Id.* at 16. In addition, the defendant's interpretation would not accommodate leave taken pursuant to the Family and Medical Leave Act of 1993 ("FMLA"), 29 U.S.C. § 2601 *et*

seq.[1] The court found that common law rules of contract interpretation, applicable to the interpretation of ERISA plans, requires that ambiguously worded contracts be interpreted so as not to result in an illegal or unenforceable construction where the wording allows for a logically acceptable construction that would render the contract legal and enforceable. (Docket No. 43 at 17 (citing *Walsh v. Schlecht,* 429 U.S. 401, 408, 97 S.Ct. 679, 685, 50 L.Ed.2d 641 (1977)) Because the plan language could be interpreted to allow for FMLA leave by finding that "representing 130 hours of work" did not require an employee actually to work 130 hours or to make self-contributions, that interpretation was required under the rules of contract interpretation. As a result, the defendant's interpretation was unseasonable and, therefore, arbitrary and capricious.

Further, the court found that, even if the defendant's interpretation of the plan language were reasonable, the plaintiff's interpretation was equally reasonable. (Docket No. 43 at 18) Under the rule of *contra proferentum,* where the plan language is susceptible to more than one reasonable interpretation, the ambiguities must be construed against the drafting party. *Id.* at 15. Because the defendant drafted the plan language, the plaintiffs interpretation had to be

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[1]Under section 2614(c) of the FMLA, during any period that an eligible employee takes leave under section 2612 of this title, the employer shall maintain coverage under any 'group health plan' . . for the duration of such leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave.

29 U.S.C. § 2614(c).

accepted. The defendant's refusal to accept this interpretation was, therefore, arbitrary and capricious.

For all of these reasons, the court found that the defendant's interpretation of the plan language as requiring an employee to work 130 hours each month or to make self-contributions in order to maintain eligibility under the plan was an unreasonable interpretation of the Continuation of Eligibility provision. As a result, the court accepted the plaintiffs interpretation that the plan required only that an employer make contributions representing 130 hours of work for each employee. Because the plaintiff's employer made such contributions, even though the plaintiff was not working due to an on-the-job injury, the plaintiff was an eligible employee in April 1999. Thus, the court entered judgment in favor of the plaintiff regarding his eligibility for coverage.

Motions for reconsideration of a non-final judgment are not addressed in the Federal Rules of Civil Procedure. In a recent decision, this court reviewed standards employed by various courts and established its own standard for motions for reconsideration:

This court generally will consider motions for reconsideration pursuant to the grounds available for motions to alter or amend under Rule 59(e) or upon a showing that the court clearly overlooked material facts or controlling law *that were presented by the party in its prior motion* and that would result in a different disposition. *Al-Sadoon v. FISI*Madison Fin. Corp.*, 188 F.Supp.2d 899, 902 (M.D. Tenn. 2002). The Sixth Circuit has held that "[m]otions to

alter or amend judgment may be granted if there is a clear error of law, newly discovered evidence, an intervening change in controlling law, or to prevent manifest injustice." *Gen Corp. Inc. v American Int'l Underwriters,* 178 F.3d 804, 834 (6th Cir. 1999) (internal citations omitted). In order to constitute newly discovered evidence, however, "the evidence must have been previously unavailable." *Id.* at 834 (citations omitted).

In its motion, the defendant presents three arguments for reconsideration of this decision. First, the defendant claims that the collective bargaining agreement entered into by the plaintiffs employer, Skilton Paving and Construction Company ("Skilton"), does not allow contributions to be made to the Fund for hours not actually worked by employees. As a result, the plan language must be interpreted to require 130 hours of actual work by an employee in order to maintain eligibility under the plan.[2] Second, the defendant argues that, because the collective bargaining agreement does

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[2]The defendant argues that section 302 of the Labor Management Relations Act, 29 U.S.C. § 186, allows payments by an employer to an employee trust fund, such as this ERISA plan, only if "the detailed basis on which such payments are to be made is specified in a written agreement with the employer. . . ." 29 U.S.C. § 186(c)(5)(B). The defendant relies on the collective bargaining agreement as that written agreement. As discussed, *infra,* the defendant's argument that the language of the collective bargaining agreement provides a reasonable basis for its interpretation of the ERISA plan must fail because the collective bargaining agreement was not submitted to the court as part of the Administrative Record and cannot be considered.

not provide for vacations or other paid leave by employees during

The plaintiff misconstrues the defendant's argument as requiring a written statement of the basis for payments to be made *by the Fund to employees.* (Docket No. 56 at *5)* That is not the requirement of section 302, which applies to payments by employers, The parties do not appear to dispute that Skilton's payments on behalf of the plaintiff were based on the collective bargaining agreement, as required by section 302. Whether Skilton's payments were proper under the terms of that agreement or constitute a breach of that agreement is not a matter before this court. which ERISA benefits will be maintained, an interpretation of the plan language that limits continued eligibility to employees who either have worked 130 hours in the relevant month or have made self-contributions is not unreasonable. Third, the defendant claims that neither Skilton nor any other employer participating in the Fund has ever requested that the Fund accommodate an employee on leave under the FMLA. As a result, an interpretation of the plan language that does not accommodate such leave is not unreasonable. (Docket No. 47)

The defendant's first two arguments depend on the language of the collective bargaining agreement entered into by the plaintiffs employer, Skilton. Although the defendant made reference to this collective bargaining agreement in its prior memoranda (Docket No. 37 at 4), the defendant did not submit the agreement as part of the administrative record and did not rely on the language of the agreement to support its arguments regarding the plaintiffs eligibility for coverage.

The defendant has made no argument that this

evidence was unavailable previously. Instead, the defendant argues in its reply that "[i]t is well settled that one of the major grounds justifying reconsideration by a trial judge of an interlocutory order is the availability of additional evidence." (Docket No. 65 at 1) (citing *United States v. Moored,* 38 F.3d 1419, 1422 (6th Cir. 1994); 18 Wright, Miller & Cooper, *Federal Practice and Procedure* § 4478 (2d ed. 1981)). The citations offered do not support the defendant's claim. In *Moored,* the Sixth Circuit considered the extent of a district court's ability to reopen or reconsider issues on remand that were not addressed specifically in the remand order from the court of appeals. *See Moored,* 38 F.3d at 1422-23. The Sixth Circuit found that the district court was not barred either by the law-of-the-case doctrine or its previous mandate on remand, and, therefore, the district court did not exceed the scope of its authority on remand by reconsidering such an issue.

Similarly, Section 4478 of Federal Practice and Procedure discusses the law-of-the-case doctrine, generally in relation to reconsideration of issues previously decided by another court. With regard to the consideration of new evidence, Section 4478 finds that "[t]he needs for stability and procedural efficiency . . . . counsel that a persuasive justification should be required to support consideration of the new evidence." 18B Wright, Miller & Cooper, *Federal Practice and Procedure* § 4478 (2d ed. 1981) (citations omitted). Wright and Miller also find in Section 4478 that the "easiest circumstances" for considering new evidence "involve new events, an issue that justifiably was not seen at an earlier time, a new issue injected by proper amendment of the pleadings, or new evidence adduced at a retrial directed for other reasons." *Id.* (citations omitted). Finally, Section 4478 states that "[e]vidence that could have been presented

earlier commonly is not considered, in keeping with the general rules that discourage slovenly or ill-considered approaches to the first trial." *Id.* (citations omitted).

Clearly, neither *Moored* nor Section 4478 support the defendant's argument that "well-settled" law allows for the submission of previously-available evidence in support of a motion for reconsideration. Under this court's standard for motions for reconsideration, evidence that was reasonably available to a party and not submitted in support of the initial motion will not be considered on a motion for reconsideration. Hence, the court will not consider the collective bargaining agreement submitted by the defendant in support of its first two arguments for reconsideration.

Even if the court were persuaded that such evidence could be considered on a motion for reconsideration generally, it would not be appropriate to do so in this ERISA case. In *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609 (6th Cir. 1998), the Sixth Circuit established the following standard for reviewing a plan administrator's decision:

> As to the merits of the action, the district court should conduct a . . . review based solely upon the administrative record, and render findings of fact and conclusions of law accordingly. The district court may consider the parties' arguments concerning the

> proper analysis of the evidentiary materials contained in the administrative record, but may not admit or consider any evidence not presented to the administrator.

Id. at 619. In this case, the defendant submitted the Administrative Record on March 2, 2000. (Docket No. 11) The Administrative Record does not contain Skilton's collective bargaining agreement. The court's previous Order contains the following note:

> The defendant also makes repeated references to the collective bargaining agreement between the employers and employees. (Docket No. 18 at 4-3; Docket No. 37 at 3-4) No collective bargaining agreement was submitted as part of the Administrative Record, and the defendant has offered no excerpts from the collective bargaining agreement in support of its position. As a result, the court has no basis for relying on the collective bargaining agreement as establishing anything relevant to this issue. The court must and shall rely on the Administrative Record submitted by the parties and the language of the Plan Document.

(Docket No.43 at 13 n.4)

> In submitting the collective bargaining agreement and other documents, the defendant did not seek to supplement the Administrative Record and did not address its failure to include this evidence in its

motion for judgment. The only argument for the admission of this evidence is offered in the affidavit of James C. Hale, Chairman of the Board of Trustees for the Tennessee Laborers Health and Welfare Fund. (Docket No. 48) In his affidavit, Hale states:

> I was in attendance and presided at the May 22, 2000 meeting of the Board of Trustees at which time the Trustees considered the eligibility of Elias Rodriguez (Rodriguez) to receive benefits. Each of the Trustees who were in attendance at the meeting was thoroughly conversant with [the] terms of the collective bargaining agreement to which Skilton Paving and Construction Company (Skilton) was a party and each of the Trustees was thoroughly conversant with the forms utilized by Skilton to report and account for contributions to the Fund on behalf of employees such as Rodriguez . . .

After a review of the Court's December 12, 2001 Memorandum, I determined to submit for consideration of the Court copies of the relevant collective bargaining agreements and reporting forms used by Skilton because all of the Trustees present at the meeting on May 22, 2000 based their decision, in part, upon the existence of these documents with which they were familiar. . . .

Id., paras. 1-2.

Under *Wilkins,* the court cannot consider evidence outside of the Administrative Record. It also would be inappropriate to consider evidence submitted after the court's decision that was available to the defendant at the time the Administrative Record was submitted. As a result, neither

Hale's affidavit nor the evidence attached thereto may be considered by the court on reconsideration of the prior judgment. *See University Hospitals v. Emerson Elec. Co.*, 202 F.3d 839, 848 n.7 (6th Cir. 2000), *reh'g and reh'g en banc denied* (March 3, 2000)[3] *see also Anderson v. Mrs. Grissom's Salads, Inc.*, 221 F.3d 1333, 2000 WL 875365, at ** 5 (6th Cir. 2000) (table) (finding that district court properly refused to

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[3]In *University Hospitals,* the Sixth Circuit noted that it would be improper for the court to consider deposition testimony from one of the plan administrators. 202 F.3d at 848 n.7. The court further found that [i]ndeed, we should be all the more reluctant to stray from the administrative record where, as here, the proffered evidence is one person's post hoc explanation of an administrative body's decision. In an analogous situation, we do not look to post-enactment statements of legislators when determining the meaning of statutes. More importantly, it strikes us as problematic to, on one hand, recognize an administrator's discretion to interpret a plan by applying a deferential 'arbitrary and capricious' standard of review, yet, on the other hand, allow the administrator to 'shore up' a decision after-the-fact by testifying as to the 'true' basis for the decision after the matter is in litigation, possible deficiencies in the decision are identified, and an attorney is consulted to defend the decision by developing creating post hoc arguments that can survive deferential review. . . . Having said this, we do not mean to imply that Mr. Draeger's testimony fails to accurately reflect the basis for the EBC's decision. The point is, we simply cannot tell from the text of the decision itself, nor from the administrative record . . . .

consider evidence that was not included in the administrative record and that was first submitted in a motion for reconsideration).

Without this supplemental evidence, the defendant's first argument is without support. Thus, the defendant's motion for reconsideration based on the language of the collective bargaining agreement will be denied. Similarly, the defendant relies on the collective bargaining agreement to support its second argument, that the failure to allow for vacations or other personal leave does not make its interpretation of the plan language unreasonable. (Docket No. 47 at 5-6) Because the collective bargaining agreement is not included in the Administrative Record, this argument, too, must fail.

The defendant's final argument for reconsideration of the court's decision is that it is not unreasonable to interpret the plan language in a way that does not allow for covered employees to maintain their benefits while on FMLA leave. The defendant relies on Hale's affidavit and the attached evidence to support much of this argument, which, again, the court cannot consider. The defendant argues that it has no responsibility to conform to the FMLA because the participating employers have not requested such an allowance. (Docket No. 47 at 8) In addition, the defendant claims that the FMLA has no applicability to the interpretation of the plan language because the plaintiff was not eligible for FMLA leave.

The defendant misapprehends the court's holding. An ERISA plan is a contract, and it must be interpreted by the court in accordance with federal common law rules of contract interpretation. *See Hunter v. Caliber Sys., Inc.*, 220 F.3d 702, 712 (6th Cir. 2000) ("General rules of contract interpretation

incorporated as part of the federal common law of contract interpretation guide [the court] in construing an ERISA plan."). One of these rules states that a contract cannot be interpreted to result in an illegal or unenforceable agreement if there is an alternate interpretation that would result in a legal, enforceable agreement. See *Walsh v. Schlecht,* 429 U.S. 401, 408, 97 S.Ct. 679, 685, 50 L.Ed.2d 641 (1977).

The defendant claims that an employee may maintain eligibility under the plan only by working 130 hours per month or self-contributing the difference between the required contribution and his or her employer's contribution for a given month. As noted by the court, this interpretation does not allow for an employee to maintain coverage under the same terms and conditions while on FMLA leave. However, the plaintiffs interpretation of the plan language, that the employer is required to submit funds representing 130 hours of work for each employee, does allow for an employee to take FMLA leave without losing ERISA coverage. Under *Walsh,* the court must interpret the contract to comply with the law. Thus, the plaintiff's interpretation must be accepted.

In addition, the defendant overlooks one other important aspect of the court's prior decision. In that decision, the court found that, even if the defendant's interpretation of the plan language is reasonable, the plaintiff's interpretation is also reasonable. (Docket No. 43 at 18) Under the rule of *contra proferentum,* the court must construe the document in favor of the non-drafting party, here, the plaintiff. *See Univ. Hospitals,* 202 F.3d at 846-47 (citing *Perez v. Aetna Life Ins. Co.,* 150 F.3d 550, 557 n.7 (6th Cir. 1998)). This is a limitation on the arbitrary and capricious standard of review. *See id.* at 846. Thus, even if the court were to accept the defendant's argument, the decision in favor of the plaintiff would remain unchanged.

For the reasons stated herein, the defendant's motion for reconsideration of the court's December 12, 2001 Order entering judgment in favor of the plaintiff regarding his eligibility for coverage under the ERISA plan in April 1999 will be denied.

An appropriate Order shall Enter.

Enter this 29th day of April, 2002.

Aleta A. Trauger
United States District Judge

Appendix D

Order of Court of Appeals Denying Rehearing

No. 02-5601

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

FILED
Apr. 29, 2004
Leonard
Green, Clerk

ELIAS RODRIGUEZ,)
)
Plaintiff–Appellant)
) **ORDER**
v.)
)
TENNESSEE LABORERS)
HEALTH & WELFARE FUND,)
Defendant–Appellee

BEFORE:
BOGGS, Chief Judge; GIBBONS, Circuit Judge; and GWIN,* District Judge.
The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and

decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT
Leonard Green, Clerk

***Hon. James Gwin, United States District Judge for the NorthernDistrict of Ohio, sitting by designation.**

Appendix E

Copies of Constitutional Provisions, Statutes and Rules

Constitutional Provisions

Constitution, Art. VI, Second Paragraph

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

Constitution, Fifth Amendment

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

Statutes

28 U.S.C. § 1254

§ 1254. Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

(2) By certification at any time by a court of appeals of any question of law in any civil or criminal case as to which instructions are desired, and upon such certification the Supreme Court may give binding instructions or require the entire record to be sent up for decision of the entire matter in controversy.

28 U.S.C. § 2201

§ 2201. Creation of remedy

(a) In a case of actual controversy within its jurisdiction, except with respect to Federal taxes other than actions brought under section 7428 of the Internal Revenue Code of 1986 [*26 USCS § 7428*], a proceeding under section 505 or 1146 of title 11, or in any civil action involving an antidumping or countervailing duty proceeding regarding a class or kind of merchandise of a free trade area country (as defined in section 516A(f)(10) of the Tariff Act of 1930 [*19 USCS § 1516a*(f)(10)]), as determined by the administering authority, any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought. Any such declaration shall have the force and effect of a final judgment or decree and shall be reviewable as such.

(b) For limitations on actions brought with respect to drug patents see section 505 or 512 of the Federal Food, Drug, and Cosmetic Act [*21 USCS § § 355* or 360b].

28 U.S.C. § 2202

§ 2202. Further relief

Further necessary or proper relief based on a declaratory judgment or decree may be granted, after reasonable notice and hearing, against any adverse party whose rights have been determined by such judgment

29 U.S.C. § 1022

§ 1022. Summary plan description

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 104(b) [*29 USCS § 1024*(b)]. The summary plan description shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 104(b)(1) [*29 USCS § 1024*(b)(1)].

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 733(a)(1) [*29 USCS § 1191b*(a)(1)]), whether a health insurance issuer (as defined in section 733(b)(2) [*29 USCS §*

1191b(b)(2)]) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this Act and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 733(a)(1) [*29 USCS § 1191b*(a)(1)]) and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of this Act [*29 USCS § 1133]).*

29 U.S.C. § 1024

§ 1024. Filing and furnishing of information

(a) Filing of annual report with Secretary.

(1) The administrator of any employee benefit plan subject to this part shall file with the Secretary the annual report for a plan year within 210 days after the close of such year (or within such time as may be required by regulations promulgated by the Secretary in order to reduce duplicative filing). The Secretary shall make copies of such annual reports available for inspection in the public document room of the Department of Labor.

(2) (A) With respect to annual reports required to be filed with the Secretary under this part, he may by regulation prescribe simplified annual reports for any pension plan which covers less than 100 participants.

(B) Nothing contained in this paragraph shall preclude the Secretary from requiring any information or data from any such plan to which this part applies where he finds such data or information is necessary to carry out the purposes of this title nor shall the Secretary be precluded from revoking provisions for simplified reports for any such plan if he finds it necessary to do so in order to carry out the objectives of this title.

(3) The Secretary may by regulation exempt any welfare benefit plan from all or part of the reporting and disclosure requirements of this title, or may provide for simplified reporting and disclosure if he finds that such requirements are inappropriate as applied to welfare benefit plans.

(4) The Secretary may reject any filing under this section--

(A) if he determines that such filing is incomplete for purposes of this part; or

(B) if he determines that there is any material qualification by an accountant or actuary contained in an opinion submitted pursuant to section 103(a)(3)(A) or section 103(a)(4)(B) [*29 USCS § 1023*(a)(3)(A) or (4)(B)].

(5) If the Secretary rejects a filing of a report under paragraph (4) and if a revised filing satisfactory to the Secretary is not

submitted within 45 days after the Secretary makes his determination under paragraph (4) to reject the filing, and if the Secretary deems it in the best interest of the participants, he may take any one or more of the following actions--

(A) retain an independent qualified public accountant (as defined in section 103(a)(3)(D) [*29 USCS § 1023*(a)(3)(D)]) on behalf of the participants to perform an audit,

(B) retain an enrolled actuary (as defined in section 103(a)(4)(C) of this Act [*29 USCS § 1023*(a)(4)(C)]) on behalf of the plan participants, to prepare an actuarial statement,

(C) bring a civil action for such legal or equitable relief as may be appropriate to enforce the provisions of this part, or

(D) take any other action authorized by this title.

The administrator shall permit such accountant or actuary to inspect whatever books and records of the plan are necessary for such audit. The plan shall be liable to the Secretary for the expenses for such audit or report, and the Secretary may bring an action against the plan in any court of competent jurisdiction to recover such expenses.

(6) The administrator of any employee benefit plan subject to this part shall furnish to the Secretary, upon request, any documents relating to the employee benefit plan, including but not limited to, the latest summary plan description (including any summaries of plan changes not contained in the summary plan description), and the bargaining agreement, trust agreement, contract, or other instrument under which the plan is established or operated.

(b) Publication of summary plan description and annual report to participants and beneficiaries of plan. Publication of the summary plan descriptions and annual reports shall be made to participants and beneficiaries of the particular plan as follows:

(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the

summary plan description, and all modifications and changes referred to in section 102(a) [*29 USCS § 1022*(a)]--

(A) within 90 days after he becomes a participant, or (in the case of a beneficiary) within 90 days after he first receives benefits, or

(B) if later, within 120 days after the plan becomes subject to this part.

The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, every fifth year after the plan becomes subject to this part an updated summary plan description described in section 102 [*29 USCS § 1022]* which integrates all plan amendments made within such five-year period, except that in a case where no amendments have been made to a plan during such five-year period this sentence shall not apply. Notwithstanding the foregoing, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, the summary plan description described in section 102 [*29 USCS § 1022]* every tenth year after the plan becomes subject to this part. If there is a modification or change described in section 102(a) [*29 USCS § 1022*(a)] (other than a material reduction in covered services or benefits provided in the case of a group health plan (as defined in section 733(a)(1) [*29 USCS § 1191b*(a)(1)])), a summary description of such modification or change shall be furnished not later than 210 days after the end of the plan year in which the change is adopted to each participant, and to each beneficiary who is receiving benefits under the plan. If there is a modification or change described in section 102(a) [*29 USCS § 1022*(a)] that is a material reduction in covered services or benefits provided under a group health plan (as defined in section 733(a)(1) [*29 USCS § 1191b*(a)(1)]), a summary description of such modification or change shall be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change. In the

alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Portability and Accountability Act of 1996 [enacted Aug. 21, 1996], providing alternative mechanisms to delivery by mail through which group health plans (as so defined) may notify participants and beneficiaries of material reductions in covered services or benefits.

(2) The administrator shall make copies of the latest updated summary plan description and the latest annual report and the bargaining agreement, trust agreement, contract, or other instruments under which the plan was established or is operated available for examination by any plan participant or beneficiary in the principal office of the administrator and in such other places as may be necessary to make available all pertinent information to all participants (including such places as the Secretary may prescribe by regulations).

(3) Within 210 days after the close of the fiscal year of the plan, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, a copy of the statements and schedules, for such fiscal year, described in subparagraphs (A) and (B) of section 103(b)(3) [*29 USCS § 1023*(b)(3)(A), (B)] and such other material (including the percentage determined under section 103(d)(11) [*29 USCS § 1023*(d)(11)]) as is necessary to fairly summarize the latest annual report.

(4) The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description,[,] and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may be regulation prescribe the

maximum amount which will constitute a reasonable charge under the preceding sentence.

(c) Statement of rights. The Secretary may by regulation require that the administrator of any employee benefit plan furnish to each participant and to each beneficiary receiving benefits under the plan a statement of the rights of participants and beneficiaries under this title.

(d) Cross references For regulations respecting coordination of reports to the Secretaries of Labor and the Treasury, see section 3004 [*29 USCS § 1204*].

29 U.S.C. § 1132

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [*29 USCS § 1109*];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [*29 USCS § 1025*(c)];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A) [*29 USCS § 1169*(a)(2)(A)]);

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1) [*29 USCS § 1021*(f)(1)], (A) to enjoin any act or practice which violates subsection (f) of section 101 [*29 USCS § 1021*(f)], or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [subtitle] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance

of actions involving delinquent contributions.

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of the Internal Revenue Code of 1986 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle [*29 USCS § § 1051* et seq., § § 1081 et seq.] (relating to participation, vesting, and funding), only if--

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 515 [*29 USCS § 1145*].

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 [*29 USCS § § 1181* et seq.] against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 733(a)(1) [*29 USCS § 1191b*(a)(1)]). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form.

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 606 or section 101(e)(1) [*29 USCS § 1166*(a)(1) or (4) or § 1021(e)(1)] with respect to a

participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $ 100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $ 1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 101(b)(4) [*29 USCS § 1021*(b)(4)]. For purposes of this paragraph, an annual report that has been rejected under section 104(a)(4) [*29 USCS § 1024*(a)(4)] for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 101(d) [*29 USCS § 1021*(d)] with respect to any participant or beneficiary or who fails to meet the requirements of section 101(e)(2) [*29 USCS § 1021*(e)(2)] with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $ 100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $ 1,000 for each violation by any person of section 101(f)(1)

[*29 USCS § 1021*(f)(1)].

(5) The Secretary may assess a civil penalty against any person of up to $ 1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g) [*29 USCS § 1021*(g)].

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 104(a)(6) [*29 USCS § 1024*(a)(4)], the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $ 100 a day from the date of such failure (but in no event in excess of $ 1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act [*42 USCS § 1320b-14*(c)(8)].

(d) Status of employee benefit plan as entity.

(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee

benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this title.

(e) Jurisdiction.

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 101(f)(1) [*29 USCS § 1021*(f)(1)]. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions.

(1) In any action under this title (other than an action described in paragraph 2) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 515 [*29 USCS § 1145]* in which a judgment in favor of the plan is awarded, the court shall award the plan--

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of--

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1986 [*26 USCS § 6621]*.

(h) Service upon Secretary of Labor and Secretary of the Treasury. A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle [*29 USCS § § 1101* et seq.]. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the

Treasury.

(i) Administrative assessment of civil penalty. In the case of a transaction prohibited by section 406 [*29 USCS § 1106]* by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of the Internal Revenue Code of 1986 [*26 USCS § 4975*(f)(4)]) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of such Code [*26 USCS § 4975*(f)(5)]) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code [*26 USCS § 4975*(e)(1)].

(j) Direction and control of litigation by Attorney General. In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor. Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this Act, or to compel him to take action required under this title, may be brought in the district court of the

United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries.

(1) In the case of--

(A) any breach of fiduciary responsibility under (or other violation of) part 4 [*29 USCS § § 1101* et seq.] by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)--

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that--

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of the Internal Revenue Code of 1986 [*26 USCS § 4975*].

(m) Penalty for improper distribution. In the case of a distribution to a pension plan participant or beneficiary in violation of section 206(e) [*29 USCS § 1056*(e)] by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $ 10,000 for each such distribution.

Rules

Rule 54(b), Federal Rules of Civil Procedure

Rule 54. Judgments; Costs

(a) Definition; Form. "Judgment" as used in these rules includes a decree and any order from which an appeal lies. A judgment shall not contain a recital of pleadings, the report of a master, or the record of prior proceedings.

(b) Judgment Upon Multiple Claims or Involving Multiple Parties. When more than one claim for relief is presented in an action, whether as a claim, counterclaim, cross-claim, or third-party claim, or when multiple parties are involved, the court may direct the entry of a final judgment as to one or more but fewer than all of the claims or parties only upon an express determination that there is no just reason for delay and upon an

express direction for the entry of judgment. In the absence of such determination and direction, any order or other form of decision, however designated, which adjudicates fewer than all the claims or the rights and liabilities of fewer than all the parties shall not terminate the action as to any of the claims or parties, and the order or other form of decision is subject to revision at any time before the entry of judgment adjudicating all the claims and the rights and liabilities of all the parties.

(c) Demand for Judgment. A judgment by default shall not be different in kind from or exceed in amount that prayed for in the demand for judgment. Except as to a party against whom a judgment is entered by default, every final judgment shall grant the relief to which the party in whose favor it is rendered is entitled, even if the party has not demanded such relief in the party's pleadings.

(d) Costs; Attorneys' Fees.

(1) Costs Other than Attorneys' Fees. Except when express provision therefor is made either in a statute of the United States or in these rules, costs other than attorneys' fees shall be allowed as of course to the prevailing party unless the court otherwise directs; but costs against the United States, its officers, and agencies shall be imposed only to the extent permitted by law. Such costs may be taxed by the clerk on one day's notice. On motion served within 5 days thereafter, the action of the clerk may be reviewed by the court.

(2) Attorneys' Fees.

(A) Claims for attorneys' fees and related nontaxable expenses shall be made by motion unless the substantive law governing the action provides for the recovery of such fees as an element of damages to be proved at trial.

(B) Unless otherwise provided by statute or order of the court, the motion must be filed and served no later than 14 days

after entry of judgment; must specify the judgment and the statute, rule, or other grounds entitling the moving party to the award; and must state the amount or provide a fair estimate of the amount sought. If directed by the court, the motion shall also disclose the terms of any agreement with respect to fees to be paid for the services for which claim is made.

(C) On request of a party or class member, the court shall afford an opportunity for adversary submissions with respect to the motion in accordance with Rule 43(e) or Rule 78. The court may determine issues of liability for fees before receiving submissions bearing on issues of evaluation of services for which liability is imposed by the court. The court shall find the facts and state its conclusions of law as provided in Rule 52(a), and a judgment shall be set forth in a separate document as provided in Rule 58.

(D) By local rule the court may establish special procedures by which issues relating to such fees may be resolved without extensive evidentiary hearings. In addition, the court may refer issues relating to the value of services to a special master under Rule 53 without regard to the provisions of subdivision (b) thereof and may refer a motion for attorneys' fees to a magistrate judge under Rule 72(b) as if it were a dispositive pretrial matter.

(E) The provisions of subparagraphs (A) through (D) do not apply to claims for fees and expenses as sanctions for violations of these rules or under *28 U.S.C. § 1927.*

Rule 59(b), Federal Rules of Civil Procedure

Rule 59. New Trials; Amendment of Judgments

(a) Grounds. A new trial may be granted to all or any of the parties and on all or part of the issues (1) in an action in which there has been a trial by jury, for any of the reasons for which

new trials have heretofore been granted in actions at law in the courts of the United States; and (2) in an action tried without a jury, for any of the reasons for which rehearings have heretofore been granted in suits in equity in the courts of the United States. On a motion for a new trial in an action tried without a jury, the court may open the judgment if one has been entered, take additional testimony, amend findings of fact and conclusions of law or make new findings and conclusions, and direct the entry of a new judgment.

(b) Time for Motion. Any motion for a new trial shall be filed no later than 10 days after entry of the judgment.

(c) Time for Serving Affidavits. When a motion for new trial is based on affidavits, they shall be filed with the motion. The opposing party has 10 days after service to file opposing affidavits, but that period may be extended for up to 20 days, either by the court for good cause or by the parties' written stipulation. The court may permit reply affidavits.

(d) On Court's Initiative; Notice; Specifying Grounds. No later than 10 days after entry of judgment the court, on its own, may order a new trial for any reason that would justify granting one on a party's motion. After giving the parties notice and an opportunity to be heard, the court may grant a timely motion for a new trial for a reason not stated in the motion. When granting a new trial on its own initiative or for a reason not stated in a motion, the court shall specify the grounds in its order.

(e) Motion to Alter or Amend Judgment. Any motion to alter or amend a judgment shall be filed no later than 10 days after entry of the judgment.

Rule 35, Federal Rules of Appellate Procedure

Rule 35. En Banc Determination

(a) When Hearing or Rehearing En Banc May Be Ordered. A majority of the circuit judges who are in regular active service may order that an appeal or other proceeding be heard or reheard by the court of appeals en banc. An en banc hearing or rehearing is not favored and ordinarily will not be ordered unless:

(1) en banc consideration is necessary to secure or maintain uniformity of the court's decisions; or

(2) the proceeding involves a question of exceptional importance.

(b) Petition for Hearing or Rehearing En Banc. A party may petition for a hearing or rehearing en banc.

(1) The petition must begin with a statement that either:

(A) the panel decision conflicts with a decision of the United States Supreme Court or of the court to which the petition is addressed (with citation to the conflicting case or cases) and consideration by the full court is therefore necessary to secure and maintain uniformity of the court's decisions; or

(B) the proceeding involves one or more questions of exceptional importance, each of which must be concisely stated; for example, a petition may assert that a proceeding presents a question of exceptional importance if it involves an issue on which the panel decision conflicts with the authoritative decisions of other United States Courts of Appeals that have addressed the issue.

(2) Except by the court's permission, a petition for an en banc hearing or rehearing must not exceed 15 pages, excluding material not counted under Rule 32.

(3) For purposes of the page limit in Rule 35(b)(2), if a party files both a petition for panel rehearing and a petition for rehearing en banc, they are considered a single document even

if they are filed separately, unless separate filing is required by local rule.

(c) Time for Petition for Hearing or Rehearing En Banc. A petition that an appeal be heard initially en banc must be filed by the date when the appellee's brief is due. A petition for a rehearing en banc must be filed within the time prescribed by Rule 40 for filing a petition for rehearing.

(d) Number of Copies. The number of copies to be filed must be prescribed by local rule and may be altered by order in a particular case.

(e) Response. No response may be filed to a petition for an en banc consideration unless the court orders a response.

(f) Call for a Vote. A vote need not be taken to determine whether the case will be heard or reheard en banc unless a judge calls for a vote.

Rule 40, Federal Rules of Appellate Procedure

Rule 40. Petition for Panel Rehearing

(a) Time to File; Contents; Answer; Action by the Court if Granted.

(1) Time. Unless the time is shortened or extended by order or local rule, a petition for panel rehearing may be filed within 14 days after entry of judgment. But in a civil case, if the United States or its officer or agency is a party, the time within which any party may seek rehearing is 45 days after entry of judgment, unless an order shortens or extends the time.

(2) Contents. The petition must state with particularity each point of law or fact that the petitioner believes the court has

overlooked or misapprehended and must argue in support of the petition. Oral argument is not permitted.

(3) Answer. Unless the court requests, no answer to a petition for panel rehearing is permitted. But ordinarily rehearing will not be granted in the absence of such a request.

(4) Action by the Court. If a petition for panel rehearing is granted, the court may do any of the following:

(A) make a final disposition of the case without reargument;

(B) restore the case to the calendar for reargument or resubmission; or

(C) issue any other appropriate order.

(b) Form of Petition; Length. The petition must comply in form with Rule 32. Copies must be served and filed as Rule 31 prescribes. Unless the court permits or a local rule provides otherwise, a petition for panel rehearing must not exceed 15 pages.

Appendix F

Petitioner's Court of Appeals Petition for Rehearing

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

ELIAS RODRIGUEZ	)	
	)	
Plaintiff-	)	
Appellee	)	**CA**
v.	)	**No.**
	)	**02–5601**
TENNESSEE LABORERS	)	
HEALTH AND WELFARE	)	
FUND, *et al.*,	)	
Defendant-Appellant	)	
	)	

DEFENDANT–APPELLANT'S MOTION FOR REHEARING AND SUGGESTION FOR REHEARING *EN BANC*

This case arises under the Employee Retirement Income Security Act of 1974 (hereinafter, ERISA), 29 U.S.C. §§ 1001, *et seq.*, and by way of introduction, before showing the exceptional importance of the Panel Opinion's errors in overlooking or misapprehending legal points as required by the Rules of Appellate Procedure, that Opinion treats the Fund as

if it were an insurance company established to sell medical and hospitalization policies to employers in the construction industry, with the employers optionally paying for coverage and purchasing coverage without regard to whether a laborer is working or not. By analogy to the Family Medical Leave Act of 1993 ("FMLA"), 29 U.S.C. §§ 2601, *et seq.*, it concludes (Opinion, pp. 7-8), that the plan itself is unreasonable in failing to provide for vacations, in disregard of the factors that *(i)* the judiciary is not empowered, in cases such as this, to review the merits of individual welfare plans and thereby to re-write them, that *(ii)* there is no proof that construction workers customarily even take vacations except between jobs, *(iii)* no proof that this employment is subject to FMLA,[1] and *(iv)* not even any proof that the number of laborers traditionally employed for limited times on specific job-sites tend to be great enough so as customarily to be subject to FMLA's requirements.

In the construction industry, laborers work and are compensated only when weather conditions permit and they are not usually paid for time not spent at a job site due to seasonal

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[1] The Opinion further failed to acknowledge Appellant's showing that if, on some rare occasion, a particular job-site and employment should be within FMLA's requirements, FMLA itself mandates that such Plan's provisions as to that employment should be modified *by operation of law* to conform to FMLA. (Appellant's Brief, p. 29, 29 U.S.C.§ 2652(b)).

or inclement weather or other reasons such as vacation, holidays, medical or personal leave. Construction projects are always of finite duration and in the course of a career a laborer will work on a variety of sites for numerous companies. The Tennessee Laborers Health and Welfare Fund (the Fund) was created decades before ERISA to provide a continuum of hospital and medical coverage for laborers employed by construction companies, and was established with an awareness of industrial conditions. Funding for the hospital and medical benefits comes from employer contributions of a fixed sum per hour of work by a laborer and initial and continuing eligibility for coverage is earned and maintained based upon a minimum number of work hours worked with corresponding amounts of employer contributions. When these minimums are not maintained, there are provisions for a laborer to personally supplement employer contributions for a limited period of time, followed by an option to maintain coverage with COBRA payments.

This case merits rehearing *en banc* because the Opinion suffers deficiencies[2] of exceptional importance in that—

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[2] In restricting the issues to those Counsel assumes the Court might be willing to consider *en banc,* Appellant does not waive nor accept as correct other departures from clear law in the Opinion, one important one of which was that the Opinion accepted the Trial Court's mistaken view that it had power to decide the case on merely a part of the administrative record. The Opinion and the Trial Court

(i) The Opinion accepts, as accurately enunciating the uniform Federal law governing ERISA issues, the panel decision of *Copeland Oaks v. Haupt,* 209 F.3d 811 (6 Cir., 2000)[3]—never approved by this Court *en banc* and rejected by other well-considered opinions (Appellant's brief, p. 31, n. 18) as conflicting with ERISA policies—his acceptance being erronious because Appellant proved that *Copeland Oaks* failed to follow, but starkly conflicts with, the governing principles this Court is obligated to follow as enunciated in *Harris Trust and Savings v. Salomon Smith Barney,* 530 U.S. 238, 120 S. Ct. 2180, 147 L. Ed. 2d 187 (2000), *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80

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rulings disregarded the fact that record submissions with the motion to modify the Trial Court's interlocutory order were, in fact, not mere *evidence* but *essential parts of the administrative record,* proven to be part of the basis of the Board's decision. *(Cf.,* Opinion, pp. 24-25, with Appellant's Brief, pp. 7-8, 37-38), the sole permissible basis for judicial review.

[3] The Opinion's assumption that the *Copeland Oaks* rule has some application to this case arises solely from the fact that the Opinion failed to accurately state the facts: It was not the decision of the Board that it had refund rights to $57,139.94, but refund rights to the full amount mistakenly paid out by it, $238,638.11, because Rodriguez was not qualified for *any benefits.* The $57,139.94 was merely a compromise amount the Fund offered Rodriguez upon certain conditions, which offer Rodriguez rejected by filing this action.

(1989), and *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987), and

(ii) The Opinion does not accurately state and determine the issues raised by the appellant, whose contentions were rejected by rationale which itself violated universally-recognized rules governing construction of instruments always applied by the Supreme Court. Appellant respectfully insists that this ground is of exceptional importance because when the Opinion's mis-applications of law are removed, there remains nothing to support the decision of this case but mere unstated philosophical reasons.

To comply with Rule 40(2), F.R.App.P., there follows a more thorough detailing of these two grounds as to which the Opinion "overlooked or misapprehended" legal points fully briefed by Appellant:

First: (a) The Opinion is erroniously based upon the incorrect premise that *Copeland Oaks v. Haupt,* 209 F.3d 811 (6 Cir., 2000), is authoritative[4] when in fact, that decision violates the Supreme Court's decisions cited in the Rule 35(a)

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[4] No matter how long respected and widely accepted, a judicial decision based upon claimed construction of a constitutional or statutory provision is not legally authoritative when the construction is shown to conflict with the provision construed, *Erie Railroad Co. v. Tompkins,* 304 U.S. 64, 68, 58 S. Ct. 817, 823, 82 L. Ed. 1188, 1195 (1938).

paragraph *(supra,* pp. 3-4, sub-paragraph *(i))*. Those authorities establish that the basic premise for construing ERISA provisions is the common law of trusts, which the Supreme Court proved both by ERISA's provisions and its legislative history. *Copeland Oaks* took as its basic legal premise one without any foundation either in the statute, in the legislative history, or in Supreme Court decisions—the law of insurance, which is wholly unrelated to the law of trusts. Insurance law is a body of law applicable mostly to the for-profit corporation which sells (for premiums) the benefit of shifting from the customer to itself the risk of monetary loss from death, injury, sickness, home-fires, earthquakes, and other such casualties or calamities. The insurance-law phrase "make whole," which instantly appears in word searches of treatises and encyclopedia articles on insurance, is not to be found in such works on the law of trusts. It is no part of the law of trusts. Under ERISA trusts (and certainly Taft-Hartley Trusts, as here), the trust generally receives no premium or contribution from the employee, whether that person be a real working employee or merely a non-working pretended employee.

Second: The Opinion presented the ambiguity issue as if the parties disputed whether the word "representing"[5] was

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[5] While there was colloquy in oral argument as to the fitness of the choice of "representing" in the way the trust documents used it, this may be the most fitting word that could have been selected: The only place "representing" is used in the United States Code, in such context, is 26 U.S.C.

ambiguous, when both parties agreed *in their briefs* (Appellant's Brief, p. 25; Appellee's Brief, p.13) that the word unambiguously means "stands for," with which the Court agreed (Opinion, p. 7). But as "represent" appeared in the phrase "representing at least 130 hours of work" (about contributions an employer is permitted and required to make), the Fund demonstrated that for ambiguity to exist, a different phrase, "hours of work," would have to be shown to be susceptible to at least *two alternative rational meanings*. The Fund proved there was no ambiguity by asserting the obvious: that "hours of work" couldn't mean its opposites, "hours of idleness" or "hours absent from work," and by challenging the Appellee to suggest other meanings. Neither the Appellee nor the Court could suggest any rational meaning "hours of work" other than "hours worked," so as to produce even arguable ambiguity. Lacking ambiguity as a reason justifying the use of *contra proferentum* to reject the Board's decision, the Panel simply substituted its own rationale for the Board's reasoning. The rational defect in the Opinion's argumentation is known in logic as the "straw man" fallacy, substituting a mis-stated argument for the actual argument made by the party, which

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§ 1276, entitled "Disposition gain *representing* accrued market discount treated as ordinary income." That is its precise meaning here, referring to data produced by computations. Here, the computations must combine hours worked in each month with work category and rate data as supplied by the governing instruments.

the Opinion did not even attempt to answer.

(b) The Opinion's rationale was contrary to the Supreme Court's holdings that, in construing a written instrument, *all relevant provisions* must be considered together, instead of treating *a single provision* in isolation, *Greene County, Kentucky v. Quinlan,* 211 U.S. 582, 29 S. Ct. 162, 53 L. Ed. 335 (1908);[6] *Crossman v. Burrill,* 179 U.S. 100, 21 S. Ct. 38, 45 L. Ed. 106 (1900);[7] *Beardsley v. Beardsley,* 138 U.S. 262, 11 S. Ct. 318, 34 L. Ed. 928 (1891).[8] In active

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[6] " In ascertaining the true meaning of instruments in writing courts do not confine their attention to single words, phrases, or sentences. The meaning is sought from the whole instrument, viewed in the light of the subject with which it deals." (211 U.S. at 594, 29 S. Ct., at 167, 53 L. Ed. , at 341-342).

[7] "The charter-party, like many mercantile instruments in common use, is drawn up in brief and disjointed sentences; and must be construed according to the intent of the parties as manifested by the whole instrument, rather than by the literal meaning of any particular clause, taken by itself." (179 U.S., at 106-107, 21 S. Ct., at 40, 45 L. Ed., at 110).

[8] " What, therefore, is the significance and import of this instrument? This, as claimed by the appellant, is not to be determined by any separate clause, but by the instrument as a whole." (138 U.S. at 266, 11 S. Ct. at 319, 34 L. Ed. at 929).

disregard of this core rule governing construction of all legal instruments, and in thereby refusing to show deference to the Board's reasoning as required by *Hunter v. Caliber Sys., Inc.*, 220 F.3d 702 (6 Cir., 2000), and other governing authorities, the Opinion made no references to the instrument's other provisions relevant to the meaning of "hours of work." These included requirements that to be covered, an employee *must have worked* a stated number of hours during a defined period at the beginning of employment, that *hours worked* during each month thereafter earn benefit entitlement for the third single following month *(e.g.,* January work earns entitlement for April of the same year), and provisions for months during which a non-working employee should be credited with work hours *as though they were worked.*[9]

Thus, the Opinion is not only affected by rational fallacies that invalidate its reasoning, it fails to follow the law by refusing to notice the relevant provisions of the instrument which prove that its only legally-valid construction is that adopted by the Board: That the employee must actually work during a month to maintain qualification, or else must have work credits available as provided by the Plan. The employer's contributions for that month are a required **consequence** of hours worked, not the *sine qua non* of eligibility. Eligibility

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[9] All described, Appellant's Brief, p. 27, with numerous references to the brief's factual summary, with record quotations and citations.

clearly is earned by working, even if the employer wrongfully fails to remit and has to be sued by the Fund or the collective bargaining representative.

Respectfully submitted,

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CERTIFICATE OF SERVICE

It is hereby certified that copies of the foregoing Petition for Rehearing *en banc*, have been mailed by First Class Mail, postage prepaid, to:

Bill Hodde, Esq.
Rivergate Park Office Building
1994 Gallatin Rd., N., Ste. 305
Madison, TN 37115

this ____ day of February, 2004.

Appendix G

Excerpts, Court of Appeals Briefs

Main Brief, pp. 30-32 (footnotes renumbered)

It should be noted at the outset, almost parenthetically, that the District Court's entire decision is justifiable—indeed, was *caused,* solely by the intrusion of common law into ERISA's entirely statutory scheme. This is a consequence of the Supreme Court's noticing the obvious, that ERISA uses many common-law terms, which, the Court concluded, mandated that the Federal courts use common-law scholarship to discern the most accurate intended meaning of those terms, a procedure commonly described as creating a Federal common law, *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 110-111, 109 S. Ct. 948, 954, 103 L. Ed. 2d 80 (1989), building upon *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41; 107 S. Ct. 1549; 95 L. Ed. 2d 39 (1987). This creation of a federal common law was essential to achieving the pre-emptive objective of there being a single, nation-wide body of law, partly statutory and partly of common-law derivation, to assure all pension and welfare plans would be governed by the same law throughout the country. Such would be impossible if state laws controlled because both statutory law and common law vary from state to state.

As implicitly recognized in the above question, this Court has adopted, from insurance law, the common-law "make whole" rule originally applicable to equitable subrogation, *Copeland Oaks v. Haupt,* 209 F.2d 811 (6 Cir., 2000), and Appellant does not ask, or even suggest, that it should revisit *Copeland Oaks.* However, it cannot be disputed that the state of holdings as to subrogation among the circuits violates the recognized purpose of ERISA, the creation of a body of uniform and consistent law applicable to pension and welfare trusts throughout the nation, because the circuits are in hopeless conflict, not only as to whether the make-whole rule is applicable, but as to the quality of trust instrument language

necessary to negate the rule's application.[1] Under the rationale of the Supreme Court's decisions on the mandate for application of a uniform federal common-law in construing and applying ERISA, there is legitimately no such thing as Sixth Circuit or First Circuit common law, but *only* Federal common law. When subrogation issues arise in relation to ERISA trusts, there is no way *any* circuit can apply the applicable uniform Federal common law because no such recognized law exists, and no such law *can ever authoritatively be said to* exist until the Supreme Court shall determine its content.

The difference in circuit opinions as to what this uniform Federal law *might be* has persisted five years without any litigant having petitioned for *certiorari.* Hence it is

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[1] *Cagle v. Bruner,* 112 F.3d 1510, 1512 (11 Cir., 1997) (holding insurance "make whole" doctrine applicable to ERISA trusts if not explicitly avowed); *Barnes v.Ind. Auto. Dealers Ass'n. of Calif. Health & Ben. Plan,* 64 F.3d 1389, 1393, 1395 (9 Cir., 1995) (indicating approval of insurance "make whole" doctrine as a "gap filler" in the absence of subrogation provision giving the fund priority, but holding no subrogation right because plan provided subrogation only upon payment of benefits, which were withheld); *Harris v. Harvard Pilgrim Health Care, Inc.,* 208 F.3d 274, 280-81 (1 Cir. 2000) (declining to adopt insurance "make whole" rule as conflicting with ERISA policy); *Waller v. Hormel Foods Corp.,* 120 F.3d 138, 140 (8th Cir. 1997) (refusing to apply "make whole" rule to ERISA trusts); *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst,* 102 F.3d 1368, 1374, 1378 (5th Cir. 1996) (indicating probable disapproval of "make whole" rule as contrary to Congressional policy in ERISA).

suggested that there is only one way **any** circuit court of appeals can constructively attempt to achieve decision under uniform Federal common law: To first certify to the Supreme Court, under 28 U.S.C. § 1254(2), the question as to the content of federal law applicable to ERISA trusts—whether the make-whole doctrine applies to subrogation provisions appearing in these trusts and if so, the type of language necessary to make the doctrine inapplicable. While each appellate opinion gives its supporting reason, *Copeland Oaks* and opinions in agreement with it clearly represent the view least in accord with ERISA.

Main Brief, pp. 37-38

In view of the statutory requirement that the Fund have within its records any collective bargaining agreement, at least to the extent needed to describe "the relevant provisions of any applicable collective bargaining agreement," 29 U.S.C. § 1022(b), and with the Record showing on its face that the records of contributions were a part of the basis of its final decision (R.11, Adm.Rec., pp. 181-182, J.A., pp. 226-227), such records clearly are a part of the Administrative Record, which the District Court recognized to be the required basis of decision (R.43, Memo. of Court, p. 10, J.A., p. 569). There being no statutory or judicial requirement identifying an official whose affidavit may authenticate the record, it is submitted that the District Court erred in refusing to recognize the Administrative Record Addition, authenticated by a Fund trustee.

The Court recognized that the order it was reconsidering

was merely interlocutory (R.53, Order, J.A., pp. 612-613), but it refused to considered this remaining part of the record by applying to interlocutory-order modification the same strict requirements (including the requirement that evidence tendered be "newly discovered") (R.68,Memo. of Court, pp. 7-9, 5-6, J.A., pp. 21-23, 19-20) imposed only upon final judgments by Rule 60(b), F.R.Civ.P., even though Rule 54(b), F.R.Civ.P., applicable to all interlocutory orders, plainly says that such interlocutory "order or other form of decision is subject to revision at any time before the entry of judgment adjudicating all the claims and the rights and liabilities of all the parties." Under this language, a party would have the right to make a second motion for summary judgment with added affidavits to fill any gaps proving that there was no substantial factual dispute. And when the basis of decision is required to be an administrative record, and only parts of that record are before the court, a party clearly has the right to have the entire record considered because of the interlocutory nature of the prior order. Hence, courts generally recognize that interlocutory orders should be subject to modification when required by the law and the facts, without regard to the strict standards applicable to final judgments, *Balla v Idaho State Bd. of Corrections,* 869 F.2d 461 (9 Cir., 1989), *Persistence Software, Inc. v Object People, Inc.* 200 F.R.D 626 (N.D. Cal., 2001), *Update Art, Inc. v Charnin,* 110 F.R.D. 26 (S.D. N.Y., 1986), and *Philadelphia Reserve Supply Co. v Nowalk & Assocs.* 864 F. Supp. 1456 (E.D. Pa., 1994).

Reply Brief, pp. 3-5

Exclusion of Part of the Administrative Record from Consideration:

The District Court noticed that the parts of the administrative record as certified were missing, and directed the filing of an omitted part which favored Appellee, but then refused to consider an additional omitted part, unfavorable to Appellee, which Appellant later presented. Appellee seeks to justify this refusal by quotation from a holding of this Court that a trial court ". . . may not admit or consider any evidence *not presented to the administrator."* (Appellee's brief, p. 40).

But of course, this omitted portion of the Administrative Record not initially certified included the entire record of contributions made on Appellee's behalf, and which the initial portions of the Administrative Record filed affirmatively shows to have been presented to and considered by the Trustees in their notice of the false record of work submitted with unauthorized contributions sent in (Appellant's Brief, pp. 17, first full paragraph, and 20, first full paragraph).

The thing under consideration here is not merely "evidence" which a party may offer or not depending upon his tactics, but is the Administrative Record, which is the only thing the reviewing court **can consider.** Appellee (and the District Court) confounded "the administrative record" with "the certified administrative record." From the many thousands of documents an administrative agency or a welfare trust

possessed, many are *selected* for certification as the documents used in decision-making, but wherever selection occurs, error is possible. When such error is discovered, the error always should be corrected, instead of pretending that an earlier erronious certification was accurate.

Such was the holding in *Natural Resources Defense Council, Inc. v. Train,* 519 F.2d. 287 (App.D.C., 1975), which included:

> "As we have said the plaintiffs by way of an affidavit from their counsel made a substantial showing in the District Court that the Administrator had not filed the entire administrative record with the court. The affidavit specified several documents that had been omitted, including the Administrator's Briefing Book. Notwithstanding this showing the Administrator did not produce the Briefing Book nor did he ever claim that he had filed the entire administrative record; and the court proceeded with its review on the basis of a partial and truncated record. We think this was error.
>
> "Since the Administrator now concedes that this document is properly part of the administrative record, it should have been made available to the District Court and to the plaintiffs in that court."
> (519 F.2d, at 291-292)

This clearly correct holding demonstrates that it is the law that *all* of the administrative record used by the administrative body in decision-making should be before the reviewing court, and that determining the case on only partial excerpts from the record is reversible error.

No issue is raised about the authenticity of this portion of the administrative record, late-filed but authenticated by affidavit of one of the deciding Trustees. This meets the test of Rule 901(b)(1), F.R.Evid., "Testimony that a matter is what it is claimed to be." This meets the Rule 901(a) test for authentication for admissibility, "evidence sufficient to support a finding that the matter in question is what its proponent claims."

As these initially-omitted documents are a part of the appellate record before this Court, they should be a part of the basis of its decision. The necessity for their consideration, if decision be in accordance with law, is wholly unrelated to the law on newly-discovered evidence.